			. 101	partment of Health and Mertificate of Death		4000	10061
			Hegistrar 1. Decedent's Name (First, Middle, Last)		2. Date of Dea		3. Time of Death
	Physicia		Beulah Virginia Dare Vailland	rourt	May 7,	2005	2:15 A. M
á	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1221 11	4c. County of Dea	
	LAGITHI	iei	2085 Cove Point Road	Lusby		Calvert	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		8. Date of Birt	th 9. Bir	thplace (State or Foreign
	Director		578-44-4697 1□M 2X0F 93 Yrs.	Months Days Hours Min.	Sept 2	5, 1911 Mar	yland
	D >		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	ehov	'n		Coditori			1 ☐ Yes 2 No
	28a-f	ect	MD Calvert Lusby 10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	ountry?
	with a or	ă		20657		United Sta	· ·
	leath	era	2085 Cove Point Road 11. Marital Status 12. Was Decedent Ever in U.S. 1		ecify Yes or No		
10	fter d r Iten ulnur	표	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No	Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Whi	te, etc.
93	al', o	by	3√ Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Wh	nite
2-0	72 hours after death with the Maryland natural; or ttems 23a or 28a-f ehow Jical Examiting gual or notified a	Completed by Funeral Director	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	cedent's Usual Occupation	ina	16b. Kind of Business	/Industry
2	ithin	прi	Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of work a. DO NOT use retired)	9		
2	led w lygier her ti	S		sewife	- /Fina Adidala	Homemake Maiden Surname)	er
anc	be find the part of the other	Be	17. Father's Name (First, Middle, Last)	Alice Ma			
<u> </u>	hould d Mei mark marlo	²	Nathaniel H. Dare 19a. Informant's Name/Relationship (Type, Print) 19b. M.	ailing Address (Street and Number or Run			Zin Code)
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Menth Hygiene. The perment of Health and Menther Hygiene. The man and state of the them are set to the set of			Cove Point Road,		-	
ē,	Heal Heal tem 2		20a Method of Disposition 20b. Place of Dis	sposition (Name of	Date	20c. Location - City or	
Baltimore,	Pages ent of st: If i		41 Burial 21 Cremation 3 Li Hemoval from State	UMC Cemetery 5/10	/05	Lusby, Mar	rvland
Ħ	ortar inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Rai	usch Fu		
ä	Per		MO0542	1405 Broomes Island	Rd., P	ort Republ:	ic, MD 20676
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
	Priyai ci an ₁			as OF DEME	TIA		Onset and Death
	/Medical		resulting in death) a. Due to (or as a consequence of):	,-3 0, 9 (, 1			
	Examiner		Sequentially list conditions. b.				
	p ii	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)				
	and I-tran	Examiner	resulting in death) Last C. Due to (or as a consequence of):				
8760,	icate be executed physician and s the burial-transit	a E					
687	death certificate be executed e attending physician and of for use as the burial-transit	edical	d				
Вох	death certifice attending ph	N/A	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of de	alivery
Ď.	death e atte d for	icia	in the past 12 months? 1 Ves 2 No. 1 Petal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
P.O.	that the death ed by the atte detached for	Physician/M	9 Unknown				
	res tha igned I be det	by F	Part II. Other significant conditions contributing to death but not resulting in the		2.9	obacco use contribute t	
ord	w require been si should	ted	HIP FRAZIURE, HYPERTER	-51110	10	Yes 2. No 3. P	robably 4 Unknown
e C	as as	Completed	MACLIAR DEVENTRATION		24a. Was auto	psy prior to	utopsy findings available completion of cause of
<u> </u>	The page	Con			1 Yes	ormed? death?	s 2 No
/ita	ilclan: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Deat	h (Check only o	one)	
ō	Physi this c	2	1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpa			dence 6 Other (Spenior occurred)	ecify)
Division of Vital Records,	Attending Physician: or death. ector: After this certifice by the funeral director.	lon	27. Manner of Death 1 Matural 5 Pending (Month, Day Year) 28b. Time Injury		280. Describe	now injury occurred	
18	l or Attendl after death. Director: A in by the fu	lica	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm,		28f. Location (Street and Number or F	Tural Route Number,
Ω	after after Direct	Certification:	4 Homicide determined building, etc. (Specify)	,,,	City or To	wn, State)	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete h completely filled in by the funeral director, page		29a. Certifier Certifying Physician: To the best of my knowledge, de				
	he Ho n 24 he Fu	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/o and manner stated.	r investigation, in my opinion, death occur	red at the time,	date and place, and du	e to the cause(s)
	To t To t	×	29b. Signature and title of certifier	29c. License number	,	29d. Date signed (Mon	th, Day, Year)
}		1	11111111	126358		MAY 9	331
			The Hold of My			/ / / / /	2005
			30. Name and address of person who completed cause of death (Item 23a) (Type	pe, Print)		,	
	IO Sta			Road Suite 310. P		,	

**			1- For Registrar amend item2	State of Ma	ryland y g84	1 / Depa 4 <i>Ce</i> i	rtment of	Health a	nd Mental H	ygiene		18002
	Physici /Medio Examir	cal .	1. Decedent's Name (First, Middle, Last Dorothy L 4a. Facility Name (If not institution, give	Louise	Vo	vev	chak 4b. City, Town,	or Location of	2. Date of I Month 45	Da Q		5 6.457 M
	Funeral Director		5. Social Security Number 6. Se 219–20–1324	tirement ix 7. Age	Ce) (In yrs. la:	st birthday) Yrs.	If Under Year Months Days		A Hrs. 8. Date of E (Month, II) July	Birth Day, Year)	Wash, 9.8 925 Ma	ntiplace (State or Foreign Country) ryland
	the Maryland 28a-f show notified at	rector	Usual Residence of Decedent 10a. State 10b. County MD Washing 10e. Street and Number			Town or Lo				10a Cit	tizen of What (10d. Inside City Limits 1 ☑ Yes 2 ☐ No
"	172 hours after death with the Maryland "natural", or Items 23a or 28a-1 show adical Exartinar must be notified at	Funeral Director	620 Summit Ave. 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No			2174 Vas Decedent of i Yes, specify Cul	Hispanic Orig pan, Mexican,	in? (Specify Yes or Neuron Rican, etc.)	Ţ	J.S.A.	nencan Indian,
21215-0036	within 72 hours a lene. than "natural", o the Madical Exart	Completed by	3 🖫 Widowed 4 □ Divorced 15. Decedent's Edu (Specify only highest grad	1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: ucation te completed) College (1-4or 5+		16a. Deced	lent's Usual Occu kind of work done OO NOT use retire	pation	of working	16b. K	Specify: W	
pu	be filed tal Hyg d other event,	To Be Com	17. Father's Name (First, Middle, Last) William A. Wiseman	2	′	Admit	ting Of	18. Mother	's Name (First, Midd	le, Maiden		Medical
	1 and Health em 27 ther t		19a. Informant's Name/Relationship (7) Linda Corderman/Da 20a. Method of Disposition	aughter	20b. Pla	16426		ew Rd.,	or Rural Route Num Hagersto	wn, l		40
	permit. Pages Department of I Important: If it any injury or o		1 ⊠ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens)	1	Have 22	n Cemete Name and Addr	ery 5	/23/2005 Rest Have a Ave., H	en Fu	neral	Chape1
	nysician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the cause on each line a Due to (or as	9 0	Do not ente	er the mode of dy					Approximate Interval Between Onset and Death 3 Months
	death certificate be executed to a strending physician and dor use as the buriat-transit	ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a c. Due to (or as a d.	conseque	nce of):		-				
.O. Box 68	that the death certifica led by the attending ph detached for use as th	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tii 9 Unknown	☐ Fetal d	leath 3	Ectopic pregnand Other (specify)	sy			23d. Date of de Month	elivery Day Year
ທົ	requires een sigr	by P	Part II. Other significant conditions co	ntributing to death but	not result	ing in the ur	derlying cause g	ven in Part I.	23a. Did	j		to the cause of death? Probably 4 □Unknown
O	The la ate has page 2	se Completed	25. Was case referred to medical					26. Place		opsy formed? 2 No	24b. Were a prior to death?	
n of	ing Phys Viter this uneral dir	atlon: To B	27. Manner of Death Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day)	2	R/Outpatien 8b. Time of Injury	28c. Inju		sing Home 5 Res 28d. Describe			ecify)
=	fter fter jired in by	al Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury building, etc. sicien: To the best of	(Specify)	edge death	occurred at the t	ime date and	City or To	own, State	and manner a	Rural Route Number,
	To the Hospital within 24 hours a To the Funeral C completely filled	Medica	(Check only 2 Medicel Exami	ner: On the basis of e and manner state	examination ed.	n and/or inv	29c. Licen	se number			te signed (Mon	
	5		30. Name and address of person who co			(3a) (Type, 1	othern	Au	enue	Hay	erston	21142 In MO
	Sta Registr		MAY 2 6 20	005 32. Trans	s signatur	× A	and I				1	

			State of Maryland / Dep.			2005	18003
			1 - State Registrar Ce 1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg. I	No.	3. Time of Death
	Physici		Pauline M. Wolfe		April 30,	^{Day} 2005 Year	9:40 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Calvert County Nursing Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Prince Frederick If Under 1 Year If Under 24 Hrs.	9 Date of Birth	Calvert Co	
	Funeral Director		190-22-0202 1 M 2 T 76 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye. May 2, 19		ace (State or Foreign try) Sylvania
	pu *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Letters	neation	1140y 29 10		Od. Inside City Limits
	Maryla f shor	ō		rederick			1 ☐ Yes 2 XNo
	or 28a	by Funeral Director	MD Calvert County Prince F	10f. Zip Code	10g.	Citizen of What Coun	try?
	ath wi	ralD	2624 Sequoia Way	20678		U.S.A.	
	Items Inst.	une	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 📆 No	Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	
036	ours af	by	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: Whi	te
21215-0036	filed within 72 hours after death with the Maryland Hygiene. sther then "natural", or Itema 23a or 28a-1 show ant, the Madical Examiner must be notified at	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work	ing 16b.	. Kind of Business/Ind	lustry
7	l withir iene. r than	ошо	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		Home	
힏	at Hyg I other	Bec	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid		
yla	should be fi and Mental H a marked ot umatic evar	2	Louis Biddle	Pearl M			
Maryland	id 2 sh Ith and 27 la n traun		1	ing Address (Street and Number or Rura			
	s 1 and Heal		Linda Kay Ziman (Daughter) 202. Method of Disposition 200. Place of Disposition 200. Place of Disposition 200. Place of Disposition 200. Place of Disposition 200.	Sequoia Way, Prin	Date 20c.	Location - City or To	and 20678 wn, State
Baltimore,	Page ment c ant: If ury or		'4 Donation 5 Other (Specify) Logan Val	ley Cemetery May	, 2005 Be	llwood, Pe	ennsylvania
Ball	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Itema 23a or 28a-1 show any injury or other traumatic evant, the Medical Examiner must be notified at one.			2. Name and Address of Facility Lee 125 Southern Maryl			
I,			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	kat tolve			2 18ars
Ī.	Examiner		Due to (or as a consequence of):	tog likak			2001
	p ==	ner	Sequentially list conditions, if any, leading to initialities cause. Enter Underlying	,	4		1
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. \(\sigma \sum \) \(\sigma \)	diosetes mill	175		Sugers
760,	ite be executed iysician and he burial-transit	ical E	d =				
89			u.				
P.O. Box	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as the	Physician/Med		□Ectopic pregnancy		23d. Date of deliver	ry Day Year
o.	the de	nysic	1 ☐ Yes 2 ☐ Mo 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown 9 ☐ Unknown	Other (specify)			
	w requires that the de been signed by the should be detached	by PI	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacc	o use contribute to the	
ord	requir		hyperbusian		1 Tes	2 ∰No 3 Proba	ably 4 □Unknown
Records,	has the	Completed			24a. Was an autopsy performed:	prior to com	sy findings available apletion of cause of
	Physician: The lavithis certificate has al director, page 2	O	25. Was case referred to medical	26 Place of Death	1 Yes 2 1	No 1 ☐ Yes	2 No
<u>></u>	Physici this cer al direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatien	Other		6 □Other (Specify,)
on o	ding f	ion:	27. Manner of Death 28a. Date of Injury (Month, Day Year) 2 DAccident investigation	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred	
Division of Vital	tten deal stor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)			and Number or Rural	Route Number,
ā	ital or A irs after raf Direc led in by	Cert			City or Town, Sta		
	To the Hospital of within 24 hours af To the Funaral D completely filled in	edical	29a. Certifier (Check only one) 1 □ Certifying Physicien: To the best of my knowledge, deat 2 □ Medical Exeminer: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause ed at the time, date a	o(s) and manner as sta and place, and due to	ated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month, D	•
			30. Name and address of person who completed cause of death (Item 23a) (Type,	D46314	Ma	ay 2, 2005	
_			Paul V. Pomilla, M.D. 110 Hospital	·	rederick.	MD 20678	
	Sta Registr	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	negistr	aı	MAY 0 2 2005 Beau & had	<u> </u>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Year Physician 2005 6:30 aMay 10 Charles Wenn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c County of Death Examiner Annanolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 915 Carrollton Avenue Arunde1 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 GM 2 □ F Yrs. 51 9 Director 1953 D.C. 219-64-8357 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show the Medical Exertiner must be notified at 1 No 2 No Directo Maryland Anne Arundel Annapolis or 28a-f 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 915 Carrollton Avenue 21401 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☐ No Specify: Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced naturel Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Anne Arundel 12th2 yrs Medical transcriber General Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H tent: If item 27 is marked ott Be ပ George Wenn Marion McPherson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 is any injury or other treu once. Lecolia Wenn (Wife) 1900 A Copeland St. Annapolis, Md. 21401 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/12/05 Metro Crematory Baltimore, Md. *4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 821 West St. Annapolis, Md. Mortuary, P.A. 21401 Wm. Reese & Sons 21401 Rese MOOY83 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Omentus /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any loading to influential cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tran The law requires that the death certificate be exect Due to (or as a consequence of). Box 68760, physician

Physiclan/Medical 2 Completed

Be

P

Certification:

Medical

as the l esn

Por

detached

፩

has page 2

Director: After this certific I in by the funeral director,

Hospitel or Attending

To the

within 24 hours a To the Funerel I

P.O.

Division of Vital Records,

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death

9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Dav

23e. Did tobacco use contribute to the cause of death?

> es 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

and manner stated.

24a. Was an autopsy performed 1 ☐ Yes 2[26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manper of Math Natural

3 🗌 Suicide

4 / Homicide

29b. Signature and title of certifier

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 ☐ Could not be

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

rectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

ate Rd

Other: 4 Nursing Home 5 esidence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

St 211 Annapoles MO 2490

29a. Certifier (Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name an address of person who completed cause of death (Item 23a) Type, Print)

HORTON MO

D0057985

State Registrar 12

32, Registrar's Signature

888



	•	State of Maryland / Department of Health an 1- State Registrar Certificate of Death		iene () () 5	18005
		Decedent's Name (First, Middle, Last)	2. Date of Deat Month	h Day Year	3. Time of Death
Physici /Medic		DeMARCUS THOMAS WILLIAMS	May 7.	2005	10:48 P M
Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of D	eath	4c. County of Dea	
		Prince George's Hospital Center Cheverly		Prince G	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 1X M 2 F Yrs Months Days Hours F	Vin. (Month, Dey,	Year) 9. Bi	irthplace (State or Foreign Country)
Director		577-33-0228	Jan 16	2001	Wash., DC
and *		Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location			10d. Inside City Limits
lanyk sho	ō				1 Yes 2 □ No
he N	Director	D.C. Washington		Og. Citizen of What C	`auntai?
with with	급	1520 18th St., S.E. #3			
ING 21215-0036 be filed within 72 hours after death with the Maryland ital Hygiene. d other then "naturel", or items 23e or 28e-f show event, it is Medical Examinat must be rediffed at	Funeral	2333	2 (Specify Ves or No.	14. Race - Am	States
ter d	Š	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	uerto Rican, etc.)	Black, Wh	
ns at ris at ris at ris at	by F	If Yes, Give 1 ☐ Yes 2√2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify:	Black
e hou	ed	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Busines	
215 27 de 18	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of life. DO NOT use retired)	working		
yiene giene	E	O N/A		N/A	
othe	Bec	17. Father's Name (First, Middle, Last) 18. Mother's	Name (First, Middle, M	Maiden Surname)	
Maryland 21215-0036 d 2 should be filed within 72 hours att th and Mental Hygiene. It is marked other than "naturel", or treumatic event, it is Medical Event	To E	Eric Michael Gibson	Monique Wil	liams	
faryland 21215-0036 2 should be filed within 72 hours after death with the Marylan and Mantal Hygiene. Is marked other than "naturel", or Items 23e or 28a-f show "eumatic event, the Medical Evandriest must be rediffed at		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of	r Rural Route Number,	City or Town, State,	Zip Code)
alth a		Monique Williams / Mother 1520 18th St., S.E	E. #3 Wa	sh., DC	20020
of He		20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cametery, crematory or other place)	Date	20c. Location - City o	r Town, State
Pages nent of I		`4 Donation 5 Other (Specify) Glenwood Cemetery 5-	-16-05	Washing	ton, DC
Baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke eny injury or other treumstic.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility 1425 Maryland Ave		rtuary, Is	nc. 20002
		23a. Part 1. Enter the disease, or complications that caused the death. Do to enter the mode of dying, such as car shock, or heart failure. List only one cause on each line.			Approximate Interval Between
8760, cate be executed management the burial-transit	dical Examiner	resulting in death) Due to (or is a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):	nnet		
Box 6 eath certific	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? December 2 1 2 2 2 3 2 4 2 2 4 2 4 4 4 2 4 4		23d. Date of de Month	elivery Day Year
the d	ysi	1 Yes 2 No 9 Unknown 9 Unknown			
rdS, P quires that n signed b	d by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death? Probably 4 Munknown
VItal Records, sicien: The law requires to certificate has been signe rector, page 2 should be or	Completed		24a. Was ar autops perform	v prior to	
	0	25. Was case referred to medical 26. Place of	Death (Check only one		
	OB	examiner? 1 X Yes 2 □ No Hospital: 1 □ Inpatient 2 ▼ ER/Outpatient 3 □ DOA Other: 4 □ Nursir	ng Home 5 🗆 Reside	nce 6 Other (Sp	ecify)
on of ding Phys There this funeral di	T :u	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe ho		
ISION Attending death. Stor: After	atlo	1 Natural 5 Pending (Month, Day Feat) 2 Accident investigation for d (He) For 250 M 1 Yes 2 No	subject.	st puch	
DIVISION OT Plor Attending Phy s after death. I Director: Atter this id in by the funeral d	Certification:	3 ☐ Suicide 4 ▼ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 5 + CPS of determined	28f. Location (Sti City or Town	reet and Number or F , State) 72.1 i	Bural Route Number, Fastrulgs bring
DIVISIC To the Hospitel or Attendining 24 hours after death To the Funerel Director: completely filled in by the	edical (29a. Certifier (Check only Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death of and incomer states.			
To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License number	29	d. Date signed (Mon	th, Day, Year)
. , , ,		OCME	м	av 8, 2005	5
4		30. Name and address of person who completed are of death (Item 23a) (Type, Print) The constant of the consta			
Sta	to	31. Date (filed (Month, Day, Year) 22. Registrar's Signature		, ,	
Registr	-	MAY 1 3 2005 Some & Specie			

			For State Registrar	State of M	/larylan		artment of H			ental Hy		000	econs 37 g	100	U.E.
			Decedent's Name (First, Middle,	Last)			incate or i	Deatin		2. Date of De	Reg. No	o. U U .	J	3. Time of	Death
	Physici /Medic		Dorothy		Acker	mann				Month	Da	2005	/ear	4:00	
	Examin	er	4a. Facility Name (If not institution,	_			4b. City, Town, or		of Death		40	c. County of			
			Keswick Multi-c			fa - 4 b indb at 1	Baltimo		24 Hea				N/A		
ŀ	Funeral Director		212-07-1236	1 □ M 2/CXF	88 	last birthday) Yrs.	Months Days	Hours	Min.	8. Date of Bi (Month, D. NOV.	rth ay Year I7, I	9. Birthplace (State or Foreign Country) Virginia			
	and w		Usual Residence of Decedent 10a. State 10b. County		10c City	y, Town or Lo	cation							0d. Inside Ci	L. Limita
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iteme 23e or 28e-f ehow any injury or other treumatic event, I're Madical Examinar must be notified at once.	Ď	Maryland N/A		100. 01.	Balti							'	od. IIIside Cii 1∭Yes	-
	r 28e	Director	10e. Street and Number				10f. Zip Code				10g. Ci	itizen of Wh	at Cour	itry?	
	N with		3939 Roland Aver	nue 710			2121	1				USA		,	
	deat	Funeral	11. Marital Status	12. Was Deceden			Vas Decedent of H	ispanic Ori	gin? (Spe	cify Yes or N	0-	14. Race -			
36	or Ite	by Fu	1 Never Married 2 Married				Yes, specify Cuba ☐ Yes 2☑ No	Specify:	i, Puerto i	Hican, etc.)	ŀ	Specify:	White,		4
Maryland 21215-0036	hours tural',	d be	3 ★Widowed 4 □ Divorced 15. Decedent's	Year or Dates	:										
7.	n "na	Completed	(Specify only highest	grade completed)		(Give :	ent's Usual Occupa kind of work done o OO NOT use retired	ation du <i>ring m</i> ost I)	t of workin	ng	16b. F	Kind of Busi	ness/Ind	dustry	
212	d with	mo	Elementary/Secondary (0-12)	College (1-4or	r 5+)		Cashier	,			S	ears			
מ	al Hyg	BeC	17. Father's Name (First, Middle, La	•						(First, Middle	-				
yla	ould b Ment arked aric e	To E	Reed Mill	.er				He1	en O'	Brien					
<u>Ja</u>	2 sh and ie m		19a. Informant's Name/Relationship				g Address (Street a							Code)	
e,	1 and Health em 27 ther t		Helen Sampson 20a. Method of Disposition	Daughter	20h P		W. 37th S	Street		altimor				21211	
nor	ages nt of l t: If it		1 X Burial 2 ☐ Cremation 3	☐Removal from State	CE	ametery, crem	rk Cemete					ocation - Ci	•		d
Baltimore,	artme orteni injury		*4 □Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice		/ 10u			1					•	ary1an	
Ba	Per Pep Suny Suny		Nym	13. A	ens		Burgee-H 3631 Fa1	ls Ko	ad.	Baltim	ore.	Home, <u>Mary</u>	Ind 1and	212	11
	Life		23a. Part1. Enter the disease, or co shock, or beart failure. List on	mplications that cause ly one cause on each	ed the death line.	n. Do not ente	or the mode of dying	g, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Bety	veen
	Physician /Modical		Immediate Cause (Final disease or condition resulting in death)	О.		nonicy								Onset and D	
	/Medical Examiner		rooding in dodary	Due to (or a	s a consequ	ience of):									
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a consequ	uence of):							_		-
	ficate be executed physician and s the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c.											
Ö,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or a	s a consequ	ience of):									
8760,	cate b	dlcal		d									-		
9 X	ding p	/Me	IF FEMALE:	23c. If yes, outcom-	e of progna	201									
Вох	atten for us	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal	death 3 🗌	Ectopic pregnancy Other (specify)					23d. Date of Month		*	ear
Records, P.O.	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Physiclan/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	at tillio or do	,a.ii 5 🗆									
ű.	is that	y P	Part II. Other significant conditions	4			derlying cause give	n in Part I.		23e. Did t	obacco	use contribu	ute to th	e cause of de	eath?
rd	w require been sig should b		Dimentin	- A17he	inel 1					10	Yes 3	No 3	☐ Prob	ably 4 ∐U	nknown
900	has be	Completed								24a. Was		24b. We	re autor	sy findings a	vailable
E	The I	Con								perfo	ormed?	dea	th?		u36 OI
Vital	yeicien: Th nis certificate director, pag	Be	25. Was case referred to medical examiner?						of Death	(Check only o	one)				
0	Phys this al di	L.	1 Yes 2 No	Hospital: 1 Inpati		ER/Outpatient		4 Nur		ne 5 ☐ Resi			(Specify)	
Division of	ding f h. After funer	tlon	27. Manner of Death Natural 5 Pending	28a. Date of Inj (Month, Da	ay Year)	28b. Time of Injury	28c. Injury Work	at ? ′es 2 ⊡ N		8d. Describe	how inju	ry occurred			
is .	N or Attendi after death. Director: A d in by the fu	flca	2 Accident investigat 3 Suicide 6 Could not determine	be 290 Place of In	niury - At hor	me, farm, stre	et, factory, office	65 2 1		8f. Location (Street an	nd Number	or Bura	Route Numb	oer
	el or s after I Dire	Certification:	4 Homicide	building, e	tc. (Specify,)	-1, 120101), 511100			City or To	wn, State	9)	or maran	7100107101710	,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After sompletely filled in by the fune.	edical C	29a. Certifier (Check only one) Certifying I	Physician: To the best aminer: On the basis	ot examinati	wledge, death ion and/or inv	occurred at the timestigation, in my op	e, date and	i place, a h occurre	nd due to the d at the time,	cause(s)) and manned place, and	er as sta	ated. the cause(s)	
	o the o the omple	Med	29b. Signature and title of certifier	and manner s	iated.		29c. License		-			te signed (A			
	31-3		17,00mm 2	Ormina				2307	6			-27.6		_/, /	
6	,		30. Name and address of person wh	o completed cause of	death (Item	23a) (Type, F	Print)					61.0			
' _	/		3730 Fal	15 TRE	5	Ba	it ime re	J	Tel	712	-11				
	Star Registra		31. Date filed (Month, Day, Year) MAY 3 1 2	005 32 Regist	trar's Signati	ure Ans	et me ne								

			For State Registrar	State of Ma		artment of F rtificate of		and Mental Hy	giene	05 18007
			Decedent's Name (First, Middle, L	ast)				2. Date of Dea	ath .	3. Time of Death
	Physici /Medi		George Martin	ez Arroyo,	Sr.			Month	Day	05 1528
	Examir		4a. Facility Name (If not institution, g			4b. City, Town, o	or Location	of Death	4c. Count	y of Death
		ш	Union Memoria	l Hospital		Baltimo				n/a
	Funeral		,	Sex 7. Age 1 ★ 2 F	(In yrs. last birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Date of Birt (Month, Day	h v, Year)	Birthplace (State or Foreign Country)
ļ.	Director		090-38-5626 Usual Residence of Decedent	A 20.	57 Yrs.			Oct 31,	1947	New York
	and		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Marylan 1 show ied at	jo	Maryland N/A		D-144					1 1 Yes 2 □ No
	288	rec	Maryland N/A 10e. Street and Number		Balti	10f. Zip Code			10g. Citizen of	What Country?
	3a or	D	3450 Elm Avenue			212)11		US	
	death ms 2	nera	11. Marital Status	12. Was Decedent B		Was Decedent of F	lispanic Or	igin? (Specify Yes or No-	14. Rai	ce - American Indian,
9	after or Ite	Ē	1 ☐ Never Married 2 🙀 Married	Armed Forces?	lo i			n, Puerto Rican, etc.)		ck, White, etc.
933	ral,	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1∭XYes 2□No	Specify:	Puerto Rica	n Specif	Hispanic
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28a-1 show ta Mudical Examiner must be multired at	Completed by Funeral Director	15. Decedent's (Specify only highest of	Education rade completed)	(Give	dent's Usual Occup	durina mos	st of working	16b. Kind of B	Business/Industry
121	vithin ne. hen	шb	Elementary/Secondary (0-12)	College (1-4or 5	+)	DO NOT use retire				14
	filed v Hygie other t		08 17. Father's Name (First, Middle, Lat	n/a	Sect	urity Off		er's Name (First, Middle,		curity
Maryland	2 should be filed withir and Mental Hygiene. Is marked other then eumatic event, It e M.	Be								
Š	should be tand Mental I s marked or umatic eve	To	Frank 19a. Informant's Name/Relationship	Arroyo	10h Mailie	a Address /Street		haela er or Rural Route Numbe	Martin	
Ma	d 2 s th an th an treu		·			sagaret .				,,
بة	iges 1 and 2 should be filed within 72 hours after death with the Maryla it of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-1 show or other treumatic event, it e M. dical Examiner must be mutified at		George M. Arroy 20a. Method of Disposition	0, Jr. / Sc	20b. Place of Dispo	sition (Name of	- 1	Court, Timo		D 21093 - City or Town, State
<u>o</u>	Pages nent of I int: If it		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec			natory or other pla	1	5/28/05		
Baltimore,	artme orten injury	l in	2. Signature Fun al Service Liv	70	Dulaney V	Valley Me			Timoniu	m, Maryland
Ba	permit. Pages 1 and 2 Department of Health s Importent: If item 27 Is eny injury or other tre		Bryan W. Clar	11031				Home of Du Road, Timon	laney V ium, MD	Malley Inc. 21093
			23a. Part1. Enter the disease, or co shock, or hear failure. List on	mplications that caused y one cause on each lin	the death. Do not ent					Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	MUO	cardia!	I Ins	Far	ction		Onset and Death
	/Medical Examiner		resulting in death)	Due terr as a	a consequence of):		de l'Orden			
	-Adimire	_	Sequentially list conditions,	b						
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying that initiated events	Due to (or as a	consequence of):					
	and and II-trar	хап	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
8760,	cate be executed physician and the burial-transit	a E								
687	phys phys s the	dical		d						
	eath certific attending p I for use as	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				33d Da	ite of delivery
Вох	atter	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant at	2 Fetal death 3	Ectopic pregnancy Other (specify)	У			onth Day Year
o.	that the de ed by the detached	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		2 o mor (apoony) _				
٩	The law requires that the death certificate be executed tte has been signed by the attending physician and tage 2 should be detached for use as the burial-transit		Part II. Other significant conditions	contributing to death bu	t not resulting in the u	nderlying cause giv	en in Part I	. 23e. Did to	bacco use cont	tribute to the cause of death?
Records,	quires n sign	Completed by	Diabetes					1 □ Y	es 2 🗆 No	3 Probably 4 Munknown
00	w requir	lete						24a. Was a	an 24b.	Were autopsy findings available
Re	he lav e has age 2 :	duc						autops perfor	med?	prior to completion of cause of death?
Vital		O U	25. Was case referred to medical				26 Place	1 ☐ Yes of Death (Check only or		1 ☐ Yes 2 ☑ No
>		O.B	examiner? 1 ☐ Yes 2 ☑ Xo	Hospital:	nt 2 ER/Outpatien	t 3 DOA Oth	on	irsing Home 5 Resid		ner (Specify)
of	문 문 문 문	-	27. Many er of Death	28a. Date of Injur (Month, Day		28c. Injur	y at	28d. Describe h		
0	ath. rr: After	atlo	1 Matural 5 ☐ Pending 2 ☐ Accident investigati		Year) Injury	M 1 🗆	Yes 2□	No		
Division	or Attending ufter death. Director: After in by the fune	tific	3 ☐ Suicide 6 ☐ Could not determine		ry - At home, farm, str	eet, factory, office		28f. Location (S. City or Town	treet and Numb	per or Rural Route Number,
	s after or self or sel	Certification:							,	
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifying F (Check only one) 2 Medicel Exa	hysician: To the best of miner: On the basis of and manner state	examination and/or in	n occurred at the tir vestigation, in my o	me, date an pinion, dea	d place, and due to the c th occurred at the time, d	ause(s) and ma late and place,	anner as stated. and due to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier			29c. Licens	e number	2	29d. Date signe	d (Month, Day, Year)
0	<)un	1	MZ.	92	69	ns.	-24-05
1	1		30 Dame and address of person who	completed cause of de	ath (Item 23a) (Type,	Print)	100		^	
1			Daniel Text	ay, M.C	. Union	Memor	ial	Hospital	Balt	-24-05 Timore, MD
	Sta	_	31. Date filed (Month, Day, Year)	32. Registra	r's Signature					
	Registr	ar	MAY 3 1 20	05	It does	Se P				

	Registrar 1. Decedent's Name (First, Middle, La	State of Marylar Ba, pt. II, 25,27	001	incate of	υ σαιι ι	2. Date of Dea		3. Time of Death
hysician	Bryan R. Ander					Month May	Day Year 26, 2005	
/Medical Examiner	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	1107	4c. County of Dea	
Adminer	Shady Grove Adve	ntist Hospital		Rocks	ville		Montgome	ery
neral	5. Social Security Number 6. S	Sex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	year) 9. Bi	rthplace (State or Foreig
r	219-46-6217	1124M 2LIF 44	Yrs.			June 21		hington, Do
	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Loc	eation				10d. Inside City Limits
ō							•	1 ☐ Yes 2 🕱 No
Director	Maryland Montgon 10e. Street and Number	nery Ro	ckvill	e 10f. Zip Code			10g. Citizen of What C	country?
0	6017 Tilden Lar	ne			0050		United St	1
Funerai	11. Marital Status	12. Was Decedent Ever in U	.s. 13. V		0852 dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		erican Indian,
	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🖾 No	ĺ			Rican, etc.)		
by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2 🔀 No	Specify:		Specify: W	nite
Completed	15. Decedent's E (Specify only highest gro	ducation		ent's Usual Occup	ation during most of work	ina	16b. Kind of Business	s/Industry
l gi	Elementary/Secondary (0-12)	College (1-4or 5+)	lite. D	O NOT use retire	d)	9		
l S		4	Syst	ems_Anal			Federal Go	vernment
Be	17. Father's Name (First, Middle, Last			. ~			Maiden Sumame)	
ုင	Thorton H. Ande					beth Po		
	19a. Informant's Name/Relationship (19b. Mailin	g Address (Street	and Number or Rur	al Route Numbe	r, City or Town, State,	Zip Code) N6K1H4
	Aimee E. Hagerty/						, Ontario,	
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	Place of Disposementary, creme Monton	ition (Name of latory or other plac lery	ce)	Date	20c. Location - City of	r Town, State
	`4 ☐ Donation 5 ☐ Other (Special	'y' Cr	emator1	um, Inc.			Bethesda.	Maryland
	21. Signature of Funeral Service Lice	O 4 .	Ro	Name and Addre	ss of Facility ROD Inc. 300	ert A. Mest M	Pumphrey Fi ontromery	uneral Home Avenue
	- JANGSI		.356 Ro	ckville,	Maryland	1 20814-	2805	
	23a. Part1. Enter the disease, or com shock, or heart failure. List only	nplications that caused the deat one cause on each line.	th. Do not ente	r the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
	Immediate Cause (Final disease or condition	, oneumon	ia					Onset and Death
ı	resulting in death)	Due to (or as a consec				11	*	
	Sequentially list conditions,	b				14	/	
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	(uence of):		NFICATION APPROVE	SICAL EX	MINER	
Examin	that initiated events resulting in death) Last	c Due to (or as a conseq	unana aft.		POSONE	DBY MEDICIT		
		Due to (or as a conseq	(uence on).	a ER	TIFICATION APPLICATION			
dicai		d		CEI	U			
/Me	IF FEMALE:	22a If was outcome of progn	2001					
lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta	al death 3 🗌	Ectopic pregnancy	/		23d. Date of de Month	olivery Day Year
Physician/Medi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of o 9□ Unknown	ıeatn 5∐	Other (specify) _				
	Part II. Other significant conditions	contributing to death but not res	sulting in the un	deriving cause on	ren in Part I	23e, Did to	bacco use contribute t	to the cause of death?
d by		a due to cer	-				- 4	robably 4 Dunknown
Completed		, , , , , , , , , , , , , , , , , , , ,		<u></u>	_ · J			
du						24a. Was a autop perfor	sy prior to	utopsy findings available completion of cause of
Cor							med? death? 2. No 1 Yes	s 25 No
Be	25. Was case referred to medical examiner?	Hospital: 4		0#	26. Place of Deat			
2	1 XYes - 2 No	Hospital: 2	ER/Outpatient 28b. Time of	3□ DOA OT	4 Nursing Ho		ence 6 Other (Spe	ecify)
	27. Manner of Death 12 Vatural 5 Pending	28a. Date of Injury (Month, Day Year)	Injury	Wor	yat k? Yes 2 X No	Subject	ow injury occurred foll	
	2 Accident investigation	7 27 1700			1			Pural Claude Alumbar
		building, etc. (Specia		et, factory, onice		City or Tow	n, State) 6017	liIden Läne
			raence			Rockvil		
Certification:	3 Suicide 6 Could not be determined	outside res	and a decay of a cub-			and due to the c	ause(s) and manner a	s stated.
Certification:	3 Suicide 6 Could not be determined 4 Homicide 6 Could not be determined	hysician: To the best of my knominer: On the basis of examina	owledge, death ation and/or inv	occurred at the till estigation, in my o	pinion, death occur	red at the time, o	iate and place, and du	e to the cause(s)
	3 Suicide 4 Homicide Could not be determined 29a. Certifier (Check only one) Certifying Place Certifyin	hysician: To the best of my kno	owledge, death ation and/or inv	estigation, in my o	pinion, death occur			
Certification:	3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	hysician: To the best of my kno miner: On the basis of examina and manner stated.	owledge, death	estigation, in my o	ppinion, death occur se number	2	29d. Date signed (Mon	th, Day, Year)
Medical Certification:	3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	hysician: To the best of my kno miner: On the basis of examine and manner stated. 7. Musty	M O	29c. Licens	pinion, death occur se number 19738	2	29d. Date signed (Mon May 27	th, Day, Year)
led in by the funera Certification:	3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	hysician: To the best of my knominer: On the basis of examine and manner stated. 7. Musty	M O	29c. Licens	pinion, death occur se number 19738	2	29d. Date signed (Mon May 27	th, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State	State of Marylar			Mental Hygien	e
			Registrar 1. Decedent's Name (First, Middle, Las	**1	Certificat	e of Death	Reg. N	
	Physic	ian	Ci.	51/	2		1. 1. 1.	ay Year 3. Time of Death
	_/Medi		4a. Facility Name (If not institution, give	etroet and number)	4h Ciby	cer	may 2	7 2005 03.4JAM
	Examir	ner	TI 71 1/	1	2/ / B	Town, or Location of Dea	1	c. County of Death
-	Euparal		5. Social Security Number 6. \$	PIGNS HOSE	last birthday) If Under	Typer If Under 24 Hr	8 Date of Birth	9 Birthplace (State or Foreign
н	Funeral Director		227-46-2352	XM 2□F 65	Yrs. Months	Days Hours Mir		9. Birthplace (State or Foreign Country)
			Usual Residence of Decedent				11-21-3	1 7/1
	rylan how		10a, State 10b. County		ty, Town or Location			10d. Inside City Limits
	the Marylar 28e-f show	ctol	MD	Į.	3altimor	e		1 No
	ith th	Oire	10e. Street and Number	1 I D	10f. Zip	Code	10g. C	itizen of What Country?
	ier death with the Maryland Items 23c or 28e-f show Iter roust be notified at	Funeral Director	300 Chape 1	Gate Koo	id 9	71221		USA
	tems	nne	11. Marital Status	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 ▼No	I.S. 13. Was Dece If Yes, spe	dent of Hispanic Origin? (cify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	 Race - American Indian, Black, White, etc.
36	s afte	y F	Never Married 2 Married 3 Widowed 4 Divorced	1	1 ☐ Yes	2 No Specify:		Specify: Rlank
ô	72 hours after "naturel", or Ite	Pd t	15. Decedent's Ed		16a. Decedent's Usua	al Occupation	165	Siad of Business (Indiana
21215-0036	in 72	Completed by	(Specify only highest gra	de completed)	(Give kind of wo	rk done during most of we	orking	Kind of Business/Industry
212	filed within Hygiene. Ither then "	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Physica	Theray	pist 1	touth Care
	il Hygi other	Be C	17. Father's Name (First, Middle, Last)		TAGOLEK	18. Mother's Na	me (First, Middle, Maide	n Sumame)
lar	should be filed withir nd Mental Hygiene. marked other then imatic event, the M.	To B	Junious Boo	Ker		llrs	ula Day	25
Maryland	2 sho and N Is ma		19a. Informant's Name/Relationship (7		19b. Mailing Advass	Street and Number or F		or Town, State, Zip Code)
	of Health of Health litem 27 I		arsula D. Lawre	ence/Siskr	6219 Ko	bin Hill K	Balto.	UD 2/207
ore	ges 1 and 2 should be filed within 72 hours after death with the Maryla to C Health and Mental Hyglene. If item 27 Is marked other then "naturel", or Items 23s or 28e-f show or other treumatic event, the Marical Existint		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	Place of Disposition (Nar cometery, crematory or o	me of other place)	1	ocation - City or Town, State
Ë	Pa nen ant:		4 Donation 5 Other (Specify	K	ing Yark	6-	4-05 B	Salto. MD
Baltimore,	pernit. Page Depirtment of Importent: If any injury or once.		Signature of Funeral Service Ligen	see	22. Vitte	Aladrecor Course	e Funeral	Services
	0.D ≥ 6 0l		laugha C. Sh	elpe	8729	3 Liberty Rd.	Randallstow	n, MD 21133
			23a. Part1. Anter the disease, or comp shock, or heart failure. List only	plications that caused the deat one cause on each line.	h. Do not enter the mod	e of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Pancyton	CNIA			Onset and Death 2 Months c
	/Medical Examiner		resulting in death)	Due to (or as a conteq	uence of):			
		<u>.</u>	Sequentially list conditions,	b. Due to (or as a conseq	nia			BMONTHS
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enier Unioritying Cause (Disease or injury	Due to (or as a conseq	derice or).			
	axecul and al-trar	xar	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of);			
8760	sate be executed physician and the burial-transit	dicai E		d				
89		edic		u				
Box	leath certific attending p	<u>Z</u>	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna				23d. Date of delivery
	death e atte	lcia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2□Feta 4□Pregnant at time of d				Month Day Year
P.0	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	9 🗆 Unknown	9□ Unknown				
	res tha igned be det	by F	Part II. Other significant conditions co	ontributing to death but not res	ulting in the underlying c	ause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Records,	w requir been si should I	ted					1 ☐ Yes 2	No 3 Probably 4 Unknown
ecc	has be je 2 sh	Completed					24a. Was an	24b. Were autopsy findings available prior to completion of cause of
_		E O					autopsy performed? 1X Yes 2 □ No	death?
Vital	Physicien: The this certificate ral director, pag	Be C	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)	7 2 100 2/210
of V	S =	To I	1 ☐ Yes 27 No	Hospital: 1 K npatient 2□	ER/Outpatient 3 DO	Other: 4 Nursing	forme 5 Residence	6 □Other (Specify)
0	D 9 9		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of 2	8c. Injury at Work?	28d. Describe how inju	ry occurred
Sio	tendi Jeath. tor: A the fu	cati			М	1 ☐ Yes 2 ☐ No		
Division	or At fter d jirect n by	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factory	, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)
	pitel urs a erei [200 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1				
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Attercompletely filled in by the funer	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exem	vsicien: To the best of my kno iner: On the basis of examina	wiedge, death occurred : tion and/or investigation,	at the time, date and place in my opinion, death occ	e, and due to the cause(s irred at the time, date and) and manner as stated. d place, and due to the cause(s)
	thin the other	Mec	29b. Signature and title of certifier	and manner stated.	29c	. License number	29d. Da	ite signed (Month, Day, Year)
	F 3 F 8		PRIM					
1	7		30. Name and address of person who c	ompleted cause of death (from	23a) (Tyne Print)	1100	MI	T1 47 2005
6)		MALLAR BHA	TTACHARYA	- GOD NON	RTH WHIPE O	TREET BUTH	44 27 2005 HORE, MARYLAND 21287
(E	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture		יייייייייייייייייייייייייייייייייייייי	TONE I AND TONE OF
	Registr	ar	BACK O T	2005	In Mark	a		

			1 - For Amend Item#5 Registrar	pStatent Manylag	94 Po	ntment of Heatificate of De	alth and M eath	lental Hy	/giene	005	18010
	Physic /Medi		1. Decedent's Name (First, Middle, Last CATHERINE	ANK	BR	NWO.		2. Date of D		2005	3. Time of Death
}	Examine Funeral Director		4a. Facility Name (If not institution, give HARBOR HOS 5. Social Security Numeral 6. Se 217-38-4176	PITAL CEN				8. Date of B (Month, D 02/15	rth av, Year)	9. Birthp	n/a place (State or Foreigr try) MD
	D	tor	Usual Residence of Decedent 10a. State 10b. County MD A	nne Arundel	ty, Town or Lo	cation Len Burnie		02/15	/ 1241	1	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	3s or 28s	Funeral Director	10e. Street and Number 808 Casual Cour	rt		10f. Zip Code	21061		10g. Citize	n of What Cour	ntry? JSA
036	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-1 show the Madical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Mas Decedent of Hispa f Yes, specify Cuban, I ☐ Yes 2⊠ No	anic Origin? (Spe Mexican, Puerto Specify:	acify Yes or N Rican, etc.)		. Race - Americ Black, White, pecify:	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event. The Madical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done duri DO NOT use retired) Clerk	ing most of worki	ng		of Business/In	,
land	ould be filed of Mental Hygis arked other stic event, It stices	To Be C	17. Father's Name (First, Middle, Last) Henry Nicke	L		18	3. Mother's Name Cathe	(First, Middle rine Co		ımame)	
	1 and 2 should Health and Men tem 27 is marke other traumatic		19a. Informant's Name/Relationship (7) David A. Brown		19b. Mailir 808 C	g Address (Street and Casual Cour	Number or Rura	Burnie	er, City or 7 MD 2	own, State, Zip 1061	Code)
more	Pages 1 a nent of Hea ant: If item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State B	emetery, crar LYV16W	sition (Name of natory or other place) Crematory	May 31.	2005	Balt	tion - City or To	wn, State aryland
Ball	permit. Pag Department Important: I any injury o		21. Signal to of Funeral Service Licens	Victor P. D.	xda, Jrza Cr 15	Name and Address of arles L. S	tevens I Ave., I	Tuneral Baltimo	. Home ore MD	'2 ^{Tnc}	
	cate be executed Medical Medical Examiner the purial-transit the purial-transit	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence). Due to (or as a consequence). Due to (or as a consequence).	uence of):					MCER	Approximate Interval Between Onset and Death
DOY O	death certifi e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	Ectopic pregnancy Other (specify)			230	I. Date of delive	ry Day Year
r (SDI	The law requires that the ite has been signed by the bage 2 should be detached.	by	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the ur	derlying cause given ii	n Part I.				e cause of death?
		Completed						24a. Was auto perfo 1 🗆 Yes		4b. Were autop prior to con death? 1 Yes	osy findings available npletion of cause of
5 8	Attending Physicien: I r death. ector: After this certificat by the funeral director, po	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	ospital: Impatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury at Work?	S. Place of Death 4 Nursing Hon 2 2 No		dence 6)
	i Die	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory, office	2	8f. Location (City or To	Street and N wn, State)	lumber or Rura	Route Number,
	within 24 hours a To the Funeral C completely filled i	edical	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examin	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the time, o estigation, in my opinio	date and place, a on, death occurre	nd due to the d at the time,	cause(s) an date and pla	d manner as sta ace, and due to	ated. the cause(s)
(/)	withiu Comp	Me	29b. Signature and title of certifier	tono		29c. License nu				igned (Month, L	
10			30 Name and address of per in who co	100LA 300		RES Print) HAMOV	ER ST	TREET	T BA	LTIMOR	٤ عاعي
	Sta Registr		31. Date filed (Month, Day Year) 2005	62. Registrar's Signa	ture	م					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year Month

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 271s marked other then "neturet" or items 23a or 28a-f show any injury or other traumatic event, if a Modical Examinating the natified at once. Baltimore, Maryland 21215-0036

1 - For State Registrar

Physic /Med Exam

ian	
ian cal	
ner	
	_
compretely lined in by the funeral director, page z should be detached for use as the burial-transit	Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

Division of Vital Records, P.O. Box 68760,

ian cal	Luci	11e +	France	25	Ballwa	In2	Month May	30 20	05 3:05 AM			
ner	4a. Facility Name (If I		1 4	0 1	4b. City, Town	, or Location of Death		4c. County of Death				
	Harbo		spital (cul	er 15a	ltimore			n/a			
	5. Social Security Nur 219–22–93	72	ox	In yrs. last b	irthday) If Under 1 Yea Months Day		8. Date of Birth (Month, Day, 06/05/	Year) 1927	Birthplace (State or Foreign Country) MD			
	Usual Residence of D	Decedent 10b. County		IOc. City. Toy	wn or Location				10d. Inside City Limits			
tor	MD	N/A		,,		ore City			ty⊒Yes 2 □ No			
al Director	10e. Street and Number 1630 Jac	kson Str	eet		10f. Zip Code	21230	10	Og. Citizen of Wh	uat Country? USA			
Funeral	11. Marital Status	d 2 Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 🛣 No	er in U.S.	13. Was Decedent of If Yes, specify Co	f Hispanic Origin? (Spuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)		American Indian, White, etc.			
b		5. Decedent's Ed		168	1 ☐ Yes 2X N			Specify:	white ness/Industry			
Completed	Elementary/Second	- 1	College (1-4or 5+)		(Give kind of work don life. DO NOT use reti	red)	king					
To Be Con	17. Father's Name (F		0		Home	maker	ne (First, Middle, N		n Home			
	Martin	Byrnes				A	nne Hel	ferstay				
	19a. Informant's Name/Relationship (Type, Print) Mitchell J. Ballwanz / Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 607 E. Fort Avenue, Baltimore MD 21230											
	20a. Method of Dispo 12 Surial 2 4 Donation 5	Cremation 3	Removal from State	Cedar	of Disposition (Name of ery, crematory or other p HILL Cem.	June 3,	2005	Coc. Location - Cocation - Cocati	ity or Town, State Cnie MD			
	21. Signatur of Fun	ral dervice en	Victor P. D	oda, i	22. Name and Add Jr. Charles 1501 E	ress of Facility L. Steven Fort Aven	s Funera	l Home,	Inc. 21230			
	23a. Part1. Enter the shock, or heart	disease, or comp failure. List only of	lications that caused the	e death. Do	not enter the mode of d				Approximate Interval Between			
	Immediate Cause (Fi	inal	a. Me	tas	tatic l	ung (ance	~	Onset and Death			
	resulting in death)		Due to (or as a d			9						
ler	I if any, leading to imm	Sequentially list conditions, leading to immediate Due to (or as a consequence of):										
Examiner	Cause (Disease or in that initiated events	Cause (Disease or injury										
	resulting in death) La	st	Due to (or as a o	consequence	of):							
lcian/Medlcal	IF FEMALE:											
S	23b. Was decedent print the past 12 mm 1 Tyes 2 Tyes 9 Tyes Unknown	enths?	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tin 9□Unknown	Fetal death	3 □Ectopic pregnan 5 □ Other (specify)		23d. Date of delivery Month Day Year					
by Ph	Part II. Other signific	ant conditions co	entributing to death but i	not resulting	in the underlying cause g	given in Part I.	23e. Did toba	acco use contrib	ute to the cause of death?			
leted	#96	erlen	Sicon				1 🗆 Ye	s 2 □ No 3	Probably 4 Unknown			
Comple	Cove	mic o	abstruc	y C	disease	ery diseas	24a. Was an autopsy perform	ed? pric	re autopsy findings available or to completion of cause of tth?] Yes 2 2 No			
Be	25. Was case referre		Hospital:				h Check on one					
7.	1 Yes 2 No.	0	1 Inpatient 28a. Date of Injury	2 ER/O	utpatient 3 DOA Time of 28c. Inj		ome 5 Resider 28d. Describe how		(Specify)			
atlon	1 Natural 2 Accident	5 Pending investigation	(Month, Day Y		Injury W	ork? □Yes 2□No	200. 0000100 1101	wingary occurred				
Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injury building, etc. (- At home, fa 'Specify)	arm, street, factory, office	9	28f. Location (Stre City or Town,	eet and Number State)	or Rural Route Number,			
edical (29a. Certifier (Check only one)	Certifying Phy Medical Exam	rsician: To the best of r iner: On the basis of ex and manner state	camination ar	e, death occurred at the nd/or investigation, in my	time, date and place, opinion, death occurr	and due to the car red at the time, da	use(s) and mann te and place, and	er as stated. If due to the cause(s)			
ž	29b. Signature and tit	le of certifier		h	ura 29c. Licer	nse number	29	1- 0	Month, Day, Year)			
	30. Name and address	s of person who o	ompleted cause of deal	th (Item 23a)	(Type Print)	-5001	1 1 1 1	Day 5	0 2005			
	30015	HANOU		2 + 1	Baltimo	MADER	CITE	1225				
te .	31. Date filed (Month,	Dav. Year)	2005 32. Ragistrar's	Signaturet		· · · · · · · · · · · · · · · · · · ·		1665				
ar		MHIST	A DELLA	THE STATE	7							

Raymond Bowers 05-03590 RPD

ردر	90		1 - For State Registrar	tate of Maryland		rtment of He tificate of D			ene () ()	5	180	12
			Decedent's Name (First, Middle, Last)					2. Date of Death)	V	3. Time of D	Death
	Physic /Medi		Raymond	Eugene		Bow	ers	May 25,	2005	Year	0102	Ам
	Exami		4a. Facility Name (If not institution, give street	et and number)		4b. City, Town, or I	ocation of Death		4c. County of	of Death		
			Maryland General Hos	pital		Baltimore	j					
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la 2□F 5.4		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	lace (State or i	Foreign
ш	Director		214-56-5237	^{2□F} 54	Yrs.			08 29			D.	
	and *		Usual Residence of Decedent 10a. State 10b. County	10c, City	, Town or Lo	cation				11	Od. Inside City	Limits
	f sho	5								"	XXYes 2	
	28e-	Director	MD NA 10e. Street and Number	В	altim	10f. Zip Code		10	g. Citizen of W	hat Caus		
	with o							10	g. Citizen of w	nat Coun	uyr	
	within 72 hours after death with the Maryland ane. then "netural; or items 23e or 28e-f show re Madical Examinar must be rotified at	by Funeral	804 South Mangold 11. Marital Status 12.	Street Was Decedent Ever in U.S	3 13 1	Vas Decedent of His		acify Vas or No.	U .	S A		
	fter d	F		Armed Forces?	10.41	Vas Decedent of His Yes, specify Cuban	Mexican, Puerto	Rican, etc.)		, White,		
936	urs al	by	3√2 Widowed 4 □ Divorced	XXYes 2 □ No If Yes, Give Year or Dates:	1	☐ Yes 🏋 🏋 No	Specify:		Specify:	P	lack	
21215-0036	2 hours	Completed	15. Decedent's Education		16a. Deced	ent's Usual Occupat	ion	1	6b, Kind of Bus			
215	hin 7	ple	(Specify only highest grade co	mpleted) College (1-4or 5+)	(Give . life. [kind of work done du OO NOT use retired)	ring most of work	king			,	
21	filed withi Hygiene. other then	no:	7 7 . 1	na	Ma	chinist			Steel	Com	pany	
	e filed al Hygie other	Be	17. Father's Name (First, Middle, Last)			1	8. Mother's Nam	e (First, Middle, M				
<u>la</u>	should be and Mental I	10	Robert Lee Bower	s Sr.		1	Alma Re	ed				
Maryland	2 sho and h is ma		19a. Informant's Name/Relationship (Type,		19b. Mailin	g Address (Street an			City or Town, S	state, Zip	Code)	
	ges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiene. If item 27 is marked other then "netural", or items 23e or 28e-f show or other treumetic event, Ir a Madical Examinar must be notified at		Sybil Bowers-Wif	e	804 S	outh Mar	ngold S	treet,	Baltin	nore	, Md	2123
Baltimore,	of He of Her		20a. Method of Disposition	20b. Pla		sition (Name of atory or other place)			Oc. Location - C			
Ē	Pages nent of l int: If it		YBurial 2 ☐ Cremation 3 ☐ Remo '4 ☐ Donation 5 ☐ Other (Specify)	ran monii Quato		orial Pa	1	1/05	andal I	ato	IID M	a
alti	그 든 분 분		21. Signature of Funeral Service Licensee	(AIII	22.	Name and Address rch F/H	of Facility	1705 K	allual	LSLO	WII , PI	u
Ö	Depariment Department		Simitte	K Imes	Ma 43	rch F/H 00 Wabas	West	Baltim	ore. N	/ 1d	21215	
			23a. Part1. Enter the disease, or complication	ons the caused the death.						-	Approximate	
	Pnysician		shock, or heart failure. List only one commediate Cause (Final	aus on each ime.	to ch	5-0 4	0 4	1.			Interval Betwe Onset and De	en ath
	/Medical		disease or condition resulting in death)	Due to (or as a conseque	Jest (nas IT	even	rage				
	Examiner			1350 May	لمرجة	Vance						
,		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as consequ	nce of):	Voy	7					
	be executed sician and burial-transit	Examin	Cause. Enter Underrying Cause (Disease or injury that initiated events	Botal	Her	no Ten	المروان					
ó	exection and and rial-tr	Exa	resulting in death) Last	Due to (or as a conseque	ence of):		707-					
68760,	cate be executed physician and the burial-transit	dlcal	d	Conto.	202							
-		led		_								
Вох	death certifi e attending i id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c.	f yes, outcome of pregnan	cy				23d. Date	of deliver	у	
	0 0	icia	1 Vac 2 No	1□Live birth 2□Fetal of 1□Pregnant at time of dea		Ectopic pregnancy Other (specify)			Mont	h I	Day Yea	ar
Ö	at the de by the a	hys	9 🗆 Unknown	9 Unknown								
S, P	The law requires that the te has been signed by thoage 2 should be detache	by P	Part II Other significant conditions contributions	ting to death but not resul	ting in the un	derlying cause given	in Part J.	23e. Did toba	cco use contrib	oute to the	e cause of dea	ith?
ğ	quire n sig uld b		Parestotic (ancer				1 🗆 Yes	2 No 3	Proba	ibly 4 🗆 Unk	known
Record	s been s been	Completed	Arteria lentri	and over an	l 1	Distance		24a. Was an	24b. W	ere autop	sy findings ava	ailable
Re	The lavate has	шс	100 1 100 20 (100.00)	D1000000		1.3-lenge		autopsy	pri de de	or to corr ath?	pletion of caus	se of
Vital		C	25. Was case referred to medical				00 Pl 4 P4		No 1)	Yes :	2□ No	
S	Physicien: this certific ral director,	o B	examiner? 1 ☑ Yes 2 ☐ No Hosp	ital: 1 🔀 Inpatient 2 🗆 E	R/Outpatient	Other		h Check onl one	0 COtt			
of		 	27. Manner of Death 2	Ba. Date of Injury 2	28b. Time of	28c. Injury a	4 Hursing Ho	me 5 Residen				-
Division	or Attending F ifter death. Director: After in by the funer	Certification:	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work?	s 2 🗆 No					
/IS	iel or Attandi s after death. el Director: A ed in by the fu	fice	3 Suicide 6 Could not be	Be. Place of Injury - At hom	ne, farm, stre	et, factory, office		28f. Location (Stre	et and Number	or Rural	Route Number	r,
D	after Dire	erti	4 Homicide	building, etc. (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town,	State)			
	To the Hospitel or within 24 hours after To the Funerel Director Completely filled in E	a	29a. Certifier 1 Certifying Physicia	n: To the best of my know	ledge, death	occurred at the time.	date and place.	and due to the cau	se(s) and mann	ner as sta	ted,	
	O Ho O Fu letely	ledical	(Check only Medical Examiner:	On the basis of examination and manner stated.	on and/or inve	estigation, in my opin	ion, death occurr	ed at the time, date	and place, an	d due to	the cause(s)	
	To the within 2 To the complet	Me	296. Signature and title of certifier			29c. License r	umber	290	I. Date signed (Month, D	ay, Year)	
	CX		(Ostrem)	(J)		OCME		M	ay 25,	2005		
1	1 -1		30. Name and address of person who complete	eted cause of death (item 2	23a) (Tuna F	rint)		TI	uy 21,	2007		
1):	+ 1		T When Lieki	F. all	-5a, (+ype, F	·	Stroot	Roll+ima	o M	.1 1	01001	
	Sta	te	31. Date filed (Month, Day, Year)	3. Registrar's Signatu	re da	111 Penn	DUTEEL	Darlinor	e, Mary	Land	Z1Z01	
	Registr	_	MAY 3 1 2005	House Si	1490	0.00						

			1 For State Registrar	State of Maryland / Dep	artment of Health and entificate of Death		e _{0.05} 18013
}	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Las Henry Brow 4a. Facility Name (If not institution, give	20	4b. City, Town, or Location of Dear	2. Date of Death Month Di	ay Year 3. Time of Death 2005 6.15 A M c. County of Death
	Funeral Director		5. Social Security Number 6. Se 224-22-1007 11	ACC 7. Age (In yrs. lasi birthday, MM 2 F 7. Age (In yrs. lasi birthday,	Baltmore If Under 1 Year If Under 24 Hrs Months Days Hours Min		
	within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28a-f show the Mudical Everther must be notified at	ector	10a. State 10b. County 10e. Street and Number	10c. City, Town or Li Baltin	ocation OPC 10f. Zip Code	1 100 0	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	er death with items 23a or	Funeral Director	3409 Esther Pl	12. Was Decedent Ever in U.S. Armed Forces?	21224 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	4	itizen of What Country? 14. Race - American Indian, Black, White, etc.
21215-0036	72 hours afte 'natural', or i	þ	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest grace)	1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: ucation 16a. Dece	1 ☐ Yes 2 ☑ No Specify: Ident's Usual Occupation Is kind of work done during most of wo	160	Specify: Black Kind of Business/Industry
S	e filed Il Hygi other	Be Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+) Stee	DO NOT use retired) I Wor Ker	Bet me (First, Middle, Maidel	Hleham Steel
, Maryland	d 2 should th and Mer 7 is mark traumatic	To	Damuel Brow. 19a Informant's Name/Relationship (T. Patrice Brown	(daughter) 3409	ng Address (Street and Number or Ri ESNEV PL. BO		or Town, State, Zip Code)
Baltimore,	nit. Pages artment of ortant: If it injury or o		20a. Method of Disposition 1 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify, 21. Signature of Funeral Sanice Licens	Jacred Sacred	matory or other place)	15-05 Du	ocation - City or Town, State dalk. MD JR. Funeral Heme
	Dep Impo		Immediate Cause (Final	ilications that caused the death. Do not entine cause on each line.	07 Eastern Ave.	Balto. Ma	Approximate Interval Between Onset and Death
	/Medical Examiner	ler	if any, leading to immediate	b. Due to (or as a consequence of): Due to (or as a consequence of):			1 mon
	ate be executed hysician and the burial-transit	lical Examiner	cause. Enter Unide lying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of):	400 June		
P.O. Box 68	that the death certifica ed by the attending ph detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)	h	23d. Date of delivery Month Day Year
ords, P.	The law requires that the ite has been signed by the bage 2 should be detached.		Part II. Other significant conditions co	ntributing to death but not resulting in the u	nderlying cause given in Part I.	V'	use contribute to the cause of death?
	ilcien: The law i certificate has b rector, page 2 sh	e Completed	25. Was case referred to medical		26 Pleas of Don	24a. Was an autopsy performed? 1 Yes 28 No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
0	this al di	Certification; To B	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	t 3 DOA Other: 4 Nursing H	ome 5 A esidence 28d. Describe how injur	
<u>N</u>	T tte o		3 Suicide 6 Could not be determined	28e. Place of Injury - At home, Jarm, strubuilding, etc. (Specify) sicien: To the best of my knowledge, death	occurred at the time, date and place	and due to the cause(s)	and manner as stated
; •	to the Hospitel within 24 hours a To the Funeral E completely filled i	Medical	(Check only 2 ☐ Medicel Exemi 29b. Signature and title of certifier	ner: On the basis of examination and/or invand manner stated.	/estigation, in my opinion, death occur	red at the time, date and	d place, and due to the cause(s) te signed (Month, Day, Year)
	7		2325 02Xe	ompleted cause o death (Item 23a) (Type, I	Print) alt mare	mg Z	1224
	Sta Registr		31. Date filed (Month, Day Year) 3 1	2005 ^{32. Registrar's Signature}	Societi	(0.0)	/

State of Maryland / Department of Health and Mental Hygiene AMEND ITEM #24a PER PHY C842erbifeatte05f Depath Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dav Year Larry J. Bickett 26 May 2005 6:15p /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 01ney If Under 1 Year | If Under 24 Hrs. Montgomery General Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Oay, Year) **Funeral** 12XM 2□F Months Days Hours Director Yrs. 215-36-5562 65 23,1939 Sept. Kentucky Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 7 is marked other than "neturel", or Items 23a or 28e-f show treumetic event, the Nedical Examinatings at 10d Inside City Limits 1 ☐ Yes 2 X No Maryland Frederick Monrovia Direc 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 3828 Shakespeare Way Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. Int: If item 27 Is marked other then "neturel", or Items 23 21770 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Master Electrician 12 Electrica1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Paul Bickett ပ္ Anna Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yleen N. Bickett/ Wife other 3828 Shakespeare Way, Monrovia, Maryland 21770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 6/3/2005 permit. Page Department of Importent: If eny injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematoriun Inc. Alexandria, Virginia 21. Signature of Juneral Service 22. Name and Address of Facility Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one sause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final - Ysangunatun Privsician disease or condition resulting in death) fran ruphired Abdeminal Acres Ancerysa 3 hrs /Medical Due to (or as a consequence of): **Examiner** 1/15. thleroscleros Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) requires that the death certificate be executed the burial-transit that initiated events attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death signed by the a 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Y es 2 No of or Attending Physicien: after death. Director: After this certification director Be 25. Was case referred to medical 26. Place of Death Check onl one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospitel o within 24 hours aft To the Funerel Di 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Med. Dir 1) 0050410 05/27/05 Dent of EM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MCH hospital, 18101 Prince Philip D. 20832 MD 32 Registrar's Signature 31. Date filed (Month State 3 1 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 13:55 M BRITTON MAY 25 2005 /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BALTINGRE CITIENT OF THE STATE Examiner THE JOHNS HOPKINS HOSPITAL 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1⊠M 2□F 262-46-9266 69 Director Usuel Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r 28a-f show 1 X Yes 2 No Rockville Maryland Montgomery Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number r than "natural", or items 23a or the Medical Examinar must be 20854 17 Starlight Court United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: if Item 27 is marked other than "natural; or lite, ury or other traumatic avent, Ita Medical Exam and ury or other traumatic avent, Ita Medical Exam and 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1958–1961 1 Never Married 2 Married White 1 ☐ Yes 2 🖾 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Montgomery County College (1-4or 5+) Elementary/Secondary (0-12) School Administrator Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick Britton Rose Weiner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Britton/Wife 17 Starlight Court, Rockville, Maryland 20854 20b. Place of Disposition (Name of comptary, crematory or other place)
ParkLawn Date 20c. Location - City or Town, State 20a. Method of Disposition May 31, 2005 Important: If It any injury or o tment of 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State Rockville, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Park Memorial permit. Departn Robert A. Pumphrey Funeral Home/Rockville, In 300 West Montgomery Ave., Rockville, MD 20850-2805 21. Signature of Funerat Service Licenses once. M00198 23a. Part1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician pulmonar edem 2 weeks resulting in death) /Medical Due to (or as a consequence 1): Examiner myelogenus leukemia acute Sequentially list conditions, flam, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed Due to (or as a consequence of): burial-1 physician Physician/Medical the the attending p as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown \$ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 ☐ Probably 4 🖫 Unknown 1 ☐ Yes 2 ☐ No Completed Deen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 5 autopsy performed? certificate 2 X No 1 ☐ Yes or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 X Inpatient Other: 10 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, To the nost safter death, within 24 hours after death.

To the Funeral Director: Aft the Hospital

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

State

Registrar

Medical

29a. Certifier

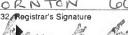
one)

(Check only

29b. Signature and title of contries

KATHERINE HORNTON 31. Date filed (Month, Day, Year) MAY 3 1 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



20

600 NORTH WOLFE STREET BALTIMORE,

MD

t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D006171

29d. Date signed (Month, Day, Year)

25,2005

MARYLAND

George Barry Jr. 05-03700 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. NJM State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month May 2005 GEORGE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3904 East Pratt Street Baltimore Baltimore City 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 MM 2 F 220-20-2130 76 Director Yrs. Neu NOU 28, 1928 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examinations the modified at 10d. Inside City Limits Director 1XYes 2 No MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3904 Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or income any injury or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: PRM 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PoliceMAN 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be conge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease shock, or heart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ATHE HOS CLOTHORE CAPADIOVAS CHIPM resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Completed 1 TYes 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 🗆 Yes 2□ No 1 ☐ Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other 4 Nursing Home 5 Residence 6 Nother (Specify) 1X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) Certification; 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred

Division of Vital Records,

within 24 hours after death To the Funerel Director..

hours after death.

29b. Signature and title of certifier MATE

5 Pending

investigation

determined

6 Could not be

1 Natural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number OCME

1 Yes 2 No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

4 Unknown

Scene

1225

May, 30, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street Baltimore, Maryland 21201

MA(MAOUT) 31. Date filed (Month, Day, Year)

32. egistrar's Signatur

State Registrar

Eli Caldwell 05-03429 NJM

	3429		_ For	State of	Maryland / Dep	partment of H	lealth and M	lental Hyg	iene	
M			1 - State Registrar		Ce	ertificate of l	Death	Re	g. No. 005	18017
			Decedent's Name (First, Middle	le, Last)				2. Date of Deat		3. Time of Death
	Physici /Medio		Elie Latif Cald	lwe11				Month May	Day Year 2005	2000 M
	Examir		4a. Facility Name (If not institution	n, give street and num	ber)	4b. City, Town, or	Location of Death		4c. County of Deatl	
			1401 Decatur	Road		Baltim	ore		Baltimo	re City
	Funeral		5. Social Security Number	6. Sex 7	7. Age (In yrs. last birthda)	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Birth	nplace (State or Foreign untry)
	Director		212-35-6889	XX M 2□F	13 Yrs.	Monard Days	Tiours IVIII	Dec. 19		land
	pu *		Usual Residence of Decedent 10a. State 10b. County	,	10c. City, Town or I	costing				
	show	<u>_</u>				Location				10d. Inside City Limits XXYes 2 □ No
	Ba-f	Director	Maryland N/A		Baltimore					
	with t		10e. Street and Number			10f. Zip Code		U	og. Citizen of What Com nited State	untry? es
	s 234	grai	511 South Pulas		dent Ever in U.S. 13	21223			f America	
	Itams I	Funerai	11. Marital Status 1XXNever Married 2 ☐ Mar	Armed Ford	ces?	. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	Irs af	by F	3 Widowed 4 Divorced	If Yes Give	9	1 ☐ Yes 🏋 No	Specify:		Specify:	1
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or Itams 23a or 28a-f show avant, the Medical Exam hat must be notified at	bed	15. Deceden	nt's Education	16a. Dec	edent's Usual Occup	ation	1	B1a l6b. Kind of Business/l	
215	within 7; ene. than "n	Completed	(Specify only highe Elementary/Secondary (0-12)	est grade completed) College (1	(Giv	e kind of work done o DO NOT use retired	during most of work	ing		
212	filed withi Hygiene. thar than int, the M	E	6th	College (1-		tudent			School	
	e filed Il Hygie othari vant, Il	a)	17. Father's Name (First, Middle,	Last)			18. Mother's Name	e (First, Middle, M	faiden Sumame)	
<u>la</u> r	should be fand Mental 8 markad of	To B	Lifton Caldwell				Stephanie	D. Doo	lev	
Maryland	s 1 and 2 should f Health and Mer itam 27 is marks other traumatic	_	19a. Informant's Name/Relations	ship (Type, Print)	19b. Mai	ling Address (Street			City or Town, State, Z.	ip Code)
	and 2 saith a n 27 is		Stephanie D. Do	oley (Moth	er) 511 8	South Pula	ski Stree	et; Balt:	imore, Mary	land 21223
Baltimore,	es 1 an of Heal fitam 2 r other		20a. Method of Disposition XXBurial 2 ☐ Cremetion	2 - 2	20b. Place of Disp	position (Name of ematory or other place	May 2	Date 2	0c. Location - City or T	
Ĕ	Pag nent int: I		`4 □Donation 5 □ Other (S	pecify)	tate	ark Cemete	1 110.5		Baltimore,	Maryland
alti	permit. Pag Department Important: I any injury o		21. Sunalis Funeral Prvin	Licens-e			s of Facility LOTT	on Park	Funeral Ho	ome
m	Per Concord		X X Cmo CACH	maux -			3620 Balt) WIIkens imore. N	s Avenue Maryland 21	1229
			23a Pag. Enter the disease, or	r complications that car t only one cause on ea	used the death. Do not er	nter the mode of dying	g, such as cardiac o	or respiratory arre	st,	Approximate Interval Between
	- Physician :	2 1	Immediate Cause (Final disease or condition	,	Drowning					Onset and Death
	/Medical		resulting in death)	Due to (o	r as a consequence of					
k	Examiner		Constitution of the constitution	b						
	Description of	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		r as a consequence of):					
	cuter	Examiner	cause. Enter Underlying that initiated events	c					-	
oʻ	icate be executed physician and s the burial-transit	Ë	resulting in death) Last	Due to (o	r as a consequence of):					
68760,	ate b hysic he bi	edicai		d						
		Med	IF FEMALE:							
Box	death certifica attending ph	an/	23b. Was decedent pregnant in the past 12 months?		ome of pregnancy th 2 Detail death 3	□Ectopic pregnancy			23d. Date of deliv	
	e deatheatheatheatheatheatheatheatheatheath	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnar	nt at time of death 5	Other (specify)			Month	Day Year
P.O.	that the de led by the a detached i	Phy			als because the state of			00 8:44		
	90	by	Part II. Other significant condition	ons contributing to dea	ith but not resulting in the	underlying cause give	en in Part I.		acco use contribute to	
Vital Records,	w requir been si should I	Completed						1 Tes	2 A No 3 Pro	bably 4 Unknown
ec	e taw has b	npie						24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
<u> </u>		Con						1 Yes 2	ed? death? □No 1 A Yes	2□ No
/ita	Physician: This certificatal director, p	Be	25. Was case referred to medical examiner?	-			26. Place of Death	Check on one		
of	Physi this c	P	1 □X/es 2 □ No	Hospital: 1 ☐ Ing			4 🗆 Ivursing Hor		ice 6 y Other (Speci	b) Scene
	ng fler	on	27. Manner of Death 1 ☐ Natural 5 ☐ Pendin	28a. Date of (Month,	Injury 28b. Time (Day Year) Injury	Work	? ,	28d. Describe how Subject	Α	
Sio	r Attanding er death. ractor: After by the fune	cat	2 Accident investig 3 Suicide 6 Could i	not he				<u> </u>	drowned	
Division	or At fter c Siraci in by	Certification:	4 Homicide determ	nined 286. Place 0	of Injury - At home, farm, sing, etc. (Specify)			28f. Location (Stre City or Town,	eet and Number or Run State) 1401 D	al Route Number, Catur Rd
	To tha Hospital or Attandi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fu					y of wester		Baltimo	re mo	. 1
	Hosi 24 ho Fung Fely f	Medical	(Check only 2 Medical	Examiner: On the bas	est of my knowledge, dea is of examination and/or in	th occurred at the tim rvestigation, in my op	e, date and place, a sinion, death occurre	and due to the cau ed at the time, dat	use(s) and manner as s se and place, and due t	stated. o the cause(s)
	thin 2 tha mple	Med	one)	and manne	or stated.	29c. License	number	200	d Data signed (Month	Chu Vanal
	₩¥ % %		29b. Signature and title of certifier	4	m.D				d. Date signed (Month,	
					·	OCM	Ľ		May, 18, 20	005
			30. Name and address of person			•	on Charact	Do1+'	M 3	1 04004
	- 01				n i D	TIT Lei	ın Street	Baltimo	re Marylan	d 21201
	Sta Registr		31. Date filed (Month, Day, Year) MAY 3 1	2005	gistrar's Signature	100				

amend item#8, per FH, G843, 5/31/05 TT State of Maryland / Department of Health and Mental Hygiefie [] [] 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Natividad Bautista Caguia 2005 May 28 8:20A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner UWings Mills

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min 206 Riverway Court; Apt.303 Baltimore
1932 9. Birthplace
Country) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 M 3 X Director 567-84-4093 72 Philippines | Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State 10d, Inside City Limits item 27 is marked other then "natural", or iteme 23a or 28e-f show other treumatic event, the Medical Examinat must be notified at MD Baltimore Owings Mills 1 Yes XXVo Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 206 Riverway Court; Apt.303 21117 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Yes XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: β Specify: Filipino X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed withIn 7/s the and Mental Hygiene. 7 Is marked other then "n Elementary/Secondary (0-12) College (1-4or 5+) 12 Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Antonio Bautista Catalina Alagar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Owings Mills, 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an ent: If item 27 Is: ury or other treu Catherine B. Caguia/Daughter 206 Riverway Court; Apt. 303 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition XXBurial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Paranaque City 6/10/05 Philippines permit. Page Department of Importent: If any injury or Manila Memorial Park ent Sivice Ligense 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of 11605 Reisterstown Rd; Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL INFARCTION Physician disease or condition resulting in death) /Medical ARTERY DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician be an/Medical as the t IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day Physicia 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERCHOLESTEROL EMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 24 No 1 Yes completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 □ No 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Director: After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospitel within 24 hours a Hospitel 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. New e and address of person who cos cause of death (Item 23a) (Type, Print) 6569 N. CHARLES 9 RA 550 E M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Ma		partment of H ertificate of			200	5	18019
	Physici		1. Decedent's Name (First, Middle	HILL AI		ADDEN		2. Date of De Month	Day	Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, HARBOR HOS	give street and number)	NTER	4b. City, Town, o	or Location of Dear		4c. County		n/a
	Funeral Director		5. Social Security Number 212–42–5736 Usual Residence of Decedent	6. Sex 7. Ag 1 ☑ M 2 ☐ F	e (In yrs. last birthda 59 Yrs.	Months Days	If Under 24 Hrs Hours Min	. (Month, Da	th ay, Year) 6,1945	9. Birthpl Count	ace (State or Foreign try) MD
	/land		10a. State 10b. County		10c. City, Town or	Location				10	Od. Inside City Limits
	a-tah	ctor	MD	N/A		Ba	ltimore	City			1 ☐ Yes 2 ☐ No
	h with the 23s or 28	Funeral Director	10e. Street and Number 2423 Annapolis	Road		10f. Zip Code	21230		10g. Citizen of W	Vhat Coun	try?
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It itiam 27 is markad other than "natural", or Items 23s or 28s-1 ahow or other traumatic avant. Its Mcdical Examble must be multilled at	by Funer	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 ♥ Divorced	12. Was Decedent Armed Forces? ed 1XXes 2 1 If Yes, Give Year or Dates:		3. Was Decedent of Hif Yes, specify Cuba	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		e America k, White, e	etc.
5-0036	72 hou natura	Completed b	15. Decedent'	s Education	16a. De	cedent's Usual Occup ve kind of work done	pation	rkina	16b. Kind of Bu		
2121	within ane. than "	mple	Elementary/Secondary (0-12)	College (1-4 or 5	lite	DO NOT use retired	d)	rking	D 31	~ .	
	e filed with Il Hygiene. othar thar vant, ILE N	Be Co	17. Father's Name (First, Middle, L	.ast)		Gas Engi			Maiden Sumam	e)	& Electric
Maryland	2 should be f and Mental b is markad of aumatic ava	ToE	Michael Cad						s E. Bow		
Mar	and 2 sh ealth and n 27 is m		19a. Informant's Name/Relationsh Jennifer A. Cad			illing Address (Street Annapol				State, Zip : 1230	Code)
Baltimore,	Pages t and 2 nent of Health int: It itam 27 i		20a. Method of Disposition 1 ☐ Burial 2XX remation		20b. Place of Dis	position (Name of rematory or other place Crematory)	1	Date 5, 2005	20c. Location - Baltim		
Baltir	permit. Pag Department Important: I any injury c		' 4 □ Donation 5 □ Other (Sp. 21. Signature 5 uneral Service)	_		22. Name and Addre	ss of Facility Stever	ns Funera	al Home.	Inc.	
			23a. Part1. Enter the disease, or o shock, or heart failure. List o	complications that caused	I the death. Do not e	1501 East	Fort A	renue, Ba	altimore	MD 2	1230 Approximate
	Pnysician	0.7	Immediate Cause (Final disease or condition resulting in death)			CEPHAL	LOPAT	HY			Interval Between Onset and Death
8760,	Medical Examiner bhysician and the brutal-transit	dical Examiner	dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a confidence)	a consequence of): a consequence of): ARY a consequence of):	AR TAC	HYCAR	DISE	ASE.	, 2	days
.O. Box 6	death certifi e attending id for use as	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	B□Ectopic pregnancy □ Other (specify)			23d. Date Mon	of deliver	y Day Year
S, P	es thi	by	Part II. Dther significant condition HYPER	S contributing to death but LIPIDE		underlying cause give	en in Part I.		obacco use contri		cause of death?
eco	aw as b	ompleted	OBESI	TY				24a. Was	an 24b. W	/ere autop:	sy findings available pletion of cause of
of Vital Record	The ate h page	Сош	HYPER	CTEN SIC	N			perfo	rmed? de	eath?	Pletion of cause of
Vit.	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:		ant 3C DOA Oth	OF.	ath Check onl o		-	
l of	g Phys er this ieral di	Ε.	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 Impaties 28a. Date of Injur	nt 2 ER/Outpati	of 28c. Injun	4 □ Nursing F		lence 6 Other		
sior	Attanding I rr death. ector: After by the funer	catio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	ation	Year) Injury		Yes 2 ☐ No				
Division	i Pite	Certification	3 Suicide 6 Could no 4 Homicide determin		ury - At home, farm, : c. (Specify)	street, factory, office		28f. Location (S City or Том	Street and Number n, State)	r or Rural i	Route Number,
	To the Hospital of within 24 hours at To the Funaral D	dical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of xaminer: On the basis of and manner sta	examination and/or	ath occurred at the tim investigation, in my of	ne, date and place pinion, death occu	, and due to the or	cause(s) and man date and place, ar	iner as stai	ted. he cause(s)
)	To the within 2 To tha complet	Me	29b. Signature and title of certifier	aff RESIL	DENT PG	YI RE	number S 60 C		29d. Date signed		
	10		30, Name and address of person w	1,3001 S	CUTH H	ANOVER	STREE	T, BAZ	LTIMOR	35 >	MO
.5.	Sta Registr	7	31. Date filed (Month, Day, Year) MAY 3 1	2005 329Registra		rede					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 9:50 P John T. Cassidv Va a005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Dital Center Chaltimore 5. Social Security Number sare Hos osedo 6. Sex Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year **Funeral** Months Days Hours 1 M 2 F 216-05-4157 91 Ацд. 9,1913 Maryland Director Usual Residence of Decedent the Maryland 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-1 show rel', or iteme 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☐ No Baltimore Maryland Essex Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Old Eastern Ave. 1813 21221 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene.
nent of Health and Mental Hygiene.
If Item 27 is marked other than "natural", or Iten
nry or other treumatic event, the Marical Estaul 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify 3 X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales & Delivery 12 Metropolitan Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John J. Cassidy ၉ Dorothy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack Cassidy / Son 3404 Orbitan Road Parkville, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 6/2/2005 Parkville, Maryland 21. Signature of Fineral Service Censee 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part1. Enter the discase or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one suse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of The law requires that the death certificate be executed Exam and Due to (or as a consequence of) Physiclan/Medical as attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9☐ Unknown detached 9 Unknown ģ peubis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🗆 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Ē 1 Yes Certification: To 1 npatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ithin 24 hours a the Funerel C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number M.O. who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760.

Division of Vital Records, P.O.

32. Registrar's Signature

anhlin

mare

baltimore

	1 - For Stete Registrar		Department of Health and Certificate of Death		2000 10021
Physicia	1. Decedent's Name (First, Middle, La			100	Day Year 3. Time of Death
/Medica Examine Funeral Director	4a. Facility Name (If not institution, giv 5. Social Security Number 6. S	Onor 7. Age (In yrs-last bin		N	4c. County of Death BALT HORE 9. Birthplace (State or Foreign Country) 192 VIRGINIA
D	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	n or Location	DETT. 10;	10d. Inside City Limits
death with the Maryland ms 23c or 28e-f show rmust be nutified at	MARYLAND N 10e. Street and Number	IA	BALTIM 10f. Zip Code		Civizen of What Country?
death wi	402 4 GLE 11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - American Indian,
VC// 0036 ours after irel', or lit	3 Widowed 4 □ Divorced	1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	erto Hican, etc.)	Black, White, etc. Specify: BLACK
Baltimore, Maryland 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or items 23e or 28e-1 show eny injury or other treumatic event. It's Modified Excriting must be multified an once.	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)	iorking	. Kind of Business/Industry
and 2 d be filed and land land land land land land land	17. Father's Name (First, Middle, Last)	STOC		ame (First, Middle, Maid	
Maryland 0 2 should be file th and Mental Hy 77 is marked oth treumatic event	19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and Number or	0	
Baltimore, sermit. Pages 1 an Department of Heal mportent: If item 2 any Injury or other pages.	20a. Method of Disposition 10 Burial 2 Cremation 3	Removal from State cemeter	Disposition (Name of y, crematory or other place)	Date 20c.	LE MD. 2/2/5 Locati n - City or Town, State
Baltir P permit. P Departme Importen eny Injury	' 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	1/1/12	22. Name and Address of acility 2/ Joseph H. Brown,		THE DEWINE HARLAND
Physician	Immediate Cause (Final	olications that caused the death. Do none cause on each line.	ot enter the mode of dying, such as cardi	ac or respiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medical Examiner	disease or condition resulting in death)	a Due to (or as a consequence of		hamic	Year
18760, cale be executed physician and sthe burial-transit direct Examiner		Due to (or as a consequence of the consequence of			
Box 6 death certification of for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
	Part II. Other significant conditions of	ontributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2 \(\sum \) No \(3 \sum \) Probably \(4 \sum \) Nnknown
The taw ate has b			00 80	-	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes
of Vita Physicien: or this certific aral director,	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out 28a. Date of Injury 28b. Ti	patient 3 DOA Other: 4 wursing	eath (Check only one) Home 5 Residence 28d. Describe how in	
Division (To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer Medical Certification.	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Accident determined		me of 28c. Injury at work? M 1 Yes 2 No m, street, factory, office		and Number or Rural Route Number.
Divisia To the Hospitel or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the		/sicien: To the best of my knowledge.	death occurred at the time, date and place	City or Town, Sta	(s) and manner as stated
To the Hosp within 24 hou To the Fune completely fi	one)	and manner stated.	or investigation, in my opinion, death occ	turred at the time, date a	and place, and due to the cause(s)
	30. Name and address of per so o c	o pleted cause of death (Item 23a) (1	D-1704 Curh Road #38	11 27	MAY 2005
State	Mar I Leav	2. Registrar's Signature	orh Road #38	Luther: !le	MD 21093
State Registrar			ande		

			1 - State Registrar	State of Maryland /		ent of H ate of L			giene	5 1	8022
	Physici		1. Decedent's Name <i>(First, Middle, L</i> as Gloria	IJean Christia	an			2. Date of De Month May	Day 27	2005	3. Time of Death 1022 A M
	/Medi Examir		4a. Facility Name (If not institution, give	street and number)	4b.	4b. City, Town, or Location of Death			4c. County of Death		1 2022
			4127 Kathland Ave	nue		Baltim	ore		Balt	imore	City
ŀ.	Funeral Director		212-42-0000	$\stackrel{\text{DX}}{\square}$ M $\stackrel{\text{ZX}}{\square}$ F $\stackrel{\text{7. Age (In yrs. last b)}}{61}$	Yrs. If U	nder 1 Year iths Days	If Under 24 Hr Hours Min		th ly, Year) 1944	Coun	lace (State or Foreign stry) yland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location					1	Od, Inside City Limits
	Marylan -f show	ţō	Maryland N/A			Rolt	imore				1 XYes 2 No
	h the	Director	10e. Street and Number		10	Zip Code	TINOLE		10g. Citizen of	What Coun	itry?
	23a c	a	4127 Kathland Av	enue		2121	5		USA		
36	s 1 and 2 should be filed within 72 hours atter death with the Maryland I Health and Mental Hygiene. I Health and Mental Hygiene. I Health and Sa or 28e-1 show itam 27 Is marked other then "natural", or itams 23a or 28e-1 show other traumatic avent. If a Medical Exertifier must be notified at	Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give	If Yes,	ecedent of His specify Cubar es 2 X No	spanic Origin? (, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)		ce - Americ ck, White,	etc.
21215-0036	2 hour	edt	15. Decedent's Ed	Year or Dates:	a. Decedent's	Usual Occupa	tion		16b. Kind of E		Black
212	hin 72 a. "ng Media	plet	(Specify only highest grade Elementary/Secondary (0-12)	de completed) Cotlege (1-4or 5+)	(Give kind o	f work done d T use retired)	uring most of w	orking	100. Killa of E	M2111622VIII	Justry
21	ad with	E C	Elementary/Secondary (6-12)		iscal S	Supervi	sor		State	of Ma:	ryland
Maryland	2 should be filed within n and Mental Hygiene. I a marked othar then raumatic avent, I're Me	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle,			
Z	ould Men narke	70	John Perry					len Mar			
Mai	nd 2 st alth and 27 la n r traun	0	19a. Informant's Name/Relationship (T Robyn Christian-M	cCord/Daughter 8	b. Maiting Add N3ム3 Ch	ress <i>(Street a</i> urch Ta	nd Number or F ane Aio	Bural Route Number	er, City or Town	, State, Zip i 11 N	Code) ИD 21244
	Health tam 27 other tr	1 8	20a. Method of Disposition	20b. Place	of Disposition	(Name of	1	Date	20c. Location		
mo	Pages nent of I int: If its		1 ☐ Burial 2 X Cremation 3 ☐ I 3 ☐ Other (Specify,	nemova: mom state	ery, crematory Cremat		$\frac{1}{10.5}$	8/05	Baltin		
Baltimore,	permit. Pages 1 a Department of Hec Importent: If itam any injury or othe		21. Signature of Funeral Service bicens					of MD,		iiore,	TID .
0	P P P P	0 0	Edward A. Gres	gorchik	299	Freder	society ick Roa	d Baltim	inc. ore, MD	2122	8
П			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death. Do ne cause on each line.	not enter the	mode of dying	, such as cardia	ic or respiratory ar	rest,		Approximate Interval Between
	Physician	i i	Immediate Cause (Final disease or condition resulting in death)	A HYIERTE WSIVE	ATHE	ROSCLE	KOTIC	CARDIOVA	SCULOR	0	Onset and Death
	/Medical Examiner		resulting in dealin)	Due to (or as a consequence	of):			210	EASE		
	0.00	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	b. Due to (or as a consequence	of):						
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	6							
0	e exectan and and and and and and and and and a	Ex	resulting in death) Last	Due to (or as a consequence	of):						
68760,	ficate be executed physician and is the burial-transit	edical	(d							
	= 0		IF FEMALE:	23c. If yes, outcome of pregnancy							
Вох	that the death certificated by the attending professional detached for use as	Physiclan/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetat death	h 3 Ectop	ic pregnancy				te of delive	ry Day Year
0	t the c by the achec	hysi	1 Yes 2 No 9 Unknown	9□ Unknown	o 🗆 outo	(Specify)					
ς, Π	res that igned to be det	by P	Part II, Other significant conditions co	ntributing to death but not resulting	in the underlyi	ng cause giver	in Part I.	23e. Did to	bacco use cont	ribute to the	e cause of death?
ord	w requires been sign should be							1 □ Y	es 2□No	3 🗌 Proba	ably 4 Nnknown
ecc	law as b 2 sl	ompleted						24a. Was a			sy findings available
E H	: The cate had page	Con						perfor	med?	death? I□Yes	
Vital Records,	Physician: The this certiticate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		Other		ath (Check only or			
o	Phys	1: To	1 XYes 2 No 27. Manner of Death	1 Linpatient 2 Liet/O	utpatient 3 Time of	DOA	4 Nuising	Home 5 Resid			Scene
ion	Attanding r death. sctor: After by the funer	atlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury M	28c. Injury a Work?	es 2 □No	200. 2000.100 11	ow injury occur.	00	
Division	l or Attanatter deat Director: in by the	ertification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, for	arm, street, fac	tory, office		28f. Location (S	treet and Numb	er or Rural	Route Number,
ā	ital or rs atte ral Dir	O	· Intilioso	building, etc. (Specify)				City or Tow	n, State)		
	To the Hospital or Attanding Ph within 24 hours atter death. To tha Funeral Director: After th completely tilled in by the funeral	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowledg ner: On the basis of examination ar and manner stated.	e, death occur nd/or investiga	red at the time tion, in my opi	, date and plac nion, death occ	e, and due to the durred at the time, o	ause(s) and ma late and place,	nner as sta and due to	ited. the cause(s)
	To the within 2 To tha complet	Σ	29b. Signature and title of certifier	***		29c. License	number	2	29d. Date signe	d (Month, D	lay, Year)
,	X		1 Muel			OCME			May, 27	, 200)5
4	'		30. Name and address of person who co		(Type, Print)	1 Penn	Street	Baltimo	ore. Mai	rv1and	1 21201
	Sta	te	31. Date filed (Month, Day Year)	32. Reistrar's Signature		a0 '				-)	~ ======
	Registr		MAYSIZ	UUS Alser S	4000						

			1 - For State Registrar	State of I	Maryla		artmer rtificat					giene	5	18023
	D		Decedent's Name (First, Middle, I	-		. 4 .					2. Date of De		V	3. Time of Death
	Physici /Medio		-0415	(AV	DAP	10WE	5				Month	Day 78 ~	Year OS-	450 PM
}	Examir		4a. Facility Name (If not institution, g					Town, or	Location (of Death		4c. Coun	ty of Death	
			Anne Arundel Med	ical Cent	er		Anı	napo	lis			Anne	Arund	le1
	Funeral		,	Sex 7. 1521 M 2□F		. last birthday)		1 Year		24 Hrs. Min.	8. Date of Bir (Month, Da SEP 3,	th v. Year)	9. Birth	place (State or Foreign
ш	Director		098-14-3384	XM ZUF	8	3 Yrs.					SEP 3,	1921	New	place (State or Foreign ntry) V York
	and *		Usual Residence of Decedent 10a. State 10b. County		10c C	ity, Town or Lo	ocation							10d. Inside City Limits
	sho	5		La Amunda I	100.0			•						1 ☐ Yes 2 ZNo
	the N	ect	Maryland Ann	e Arundel		Anr	napol:	_						
	with B or	급	2006 Quay Villa	ce Court	Unit	т 1	10f. Zip	214	'∩3			10g. Citizen of		ntry?
	72 hours after death with the Maryland natural', or items 23a or 28a-1 show dical Exaciliser cust be mailised at	Funeral Director	11. Marital Status	12. Was Decede			Mas Dass			ain? (Ca	neify Van as Na	14 De	USA	and the state of
	iter d	'n	1 Never Married 2 Married	Armed Force					n, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)	Bla	ack, White,	
38	urs af	by F	3 Widowed 4 Divorced	If Yes, Give	□ WW. s:	TT	1 🗆 Yes	2 No	Specify:			Speci	_{ity:} Wh	ite
21215-0036	2 hou	ed	15. Decedent's			16a. Dece	dent's Usua	al Occupa	ation			16b. Kind of I	Business/In	dustry
215	within 7, ene. than "n	ple	(Specify only highest of Elementary/Secondary (0-12)	grade completed) College (1-4c	(5.1)	(Give	kind of wo	rk done d se retired	<i>luring m</i> os ()	t of work.	ing			,
7	e filed within al Hygiene. other than '	Completed	Elementary/occorridary (o 12)	4	11 577	Fina	ancer					Financ	ial I	nvestment
2	be filed Ital Hygi Id other avent, I	Be	17. Father's Name (First, Middle, La	st)					18. Mothe	r's Name	First, Middle.			
<u> </u>	ould b Menta arkad atic a	To	Michael Cardam	one					He:	len '	Ventura			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any higher to other traumatic avent. Ite Medical Examiner mat be traitled at once.		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	r or Rura	I Route Numbe	er, City or Town	, State, Zip	Code)
	and 2 salth n 27 i		Lydia C. Cardamo	ne/wife		2006	Quay	Vill	age (Ct. I	Unit T1	Annap	olis,	MD 21403
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or othar tr		20a. Method of Disposition 1 Burial 2- Cremation 3		20b.	Place of Dispo cemetery, crei	osition (Nar	ne of ther place	e)		Date	20c. Location		
Ĕ	Pages nent of h ant: If its		'4 □ Donation 5 □ Other (Spec		10	tro Cre			1	5/31	/05	Ra1	timer	e. MD
alt	permit. Pag Department Important: I any injury o		21. Signature of Fune of Service Un	ensee Some	1.6	22	2. Name ar	d Addres	s of Facilit	X+ + + 7	of Mary	land T	20	C, 111
8	77 = 29		Dawn F. McD	onald	MX.	_ 2	199 Fr	eder	ick I	Road	Balti	more M	nc. n 212	28
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caus	ed the dea	th. Do not ent	ter the mod	e of dying	g, such as	cardiac o	r respiratory ar	rest,	U 212	Approximate Interval Between
15	Physician :		Immediate Cause (Final disease or condition	Car	Mille	And	20-6	-						Onset and Death
	/Medical		resulting in death)	Due to (or a	as a conse	quence of):	1		1				_	
	Examiner		Coguantially first conditions	h Cox	000	174 K	Hyp	109	cle	509	15			YK
	D #	ner	Sequentially list conditions. if any, leading to immediate cause. Enter Underlying	Due to (or a	is a conse	quence of):								7
	acute ind trans	Examiner	Cause (Disease or injury that initiated events	c										
Ö,	ate be executed hysician and the burial-transit	Ë	resulting in death) Last	Due to (or a	as a conse	quence of):								
8760,	cate be executed chysician and the burial-transit	Physician/Medicai		d										
9	eath certific attending p for use as t	Mec	IF FEMALE:									1		-
Вох	ath cattend ttend or us	an	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	2 Fet	al death 3	Ectopic pr						ate of delive	
0	the a	Sic	1 Yes 2 NHO	4□Pregnant 9□Unknown		death 5	Other (sp	ecify)				IVI	Dilli	Day Year
<u>ď</u>	that the de led by the a detached f	Phy		annetaibutine to denth	h						00. 0:44			
ŝ	ob pe	by	Part II. Other significant conditions	contributing to death	DULTION THE	suiting in the til	naeriying c	ause give	n in Parti.					ne cause of death?
20	w requir been si should	eted									1	es Z INO	3 100	ably 4 □Unknown
ec	a law has b e 2 sl	Completed									24a. Was autop	sy	prior to cor	psy findings available apletion of cause of
		Cor									perfor 1 ☐ Yes		death?	2 No
Vital Records,	Attanding Physician: The lar r death. ector: After this certificate has by the funeral director, page 2	Be	25. Was case referred to medical examiner?	Manitali						of Death	(Check only o	ne)		
of	di S	မ	1 ☐ Yes 2 ☐ No			EN/Outpatien			4 🗆 Nu		ne 5 Resid			<i>'</i>)
Ē	ing F	inol	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Ir (Month, L	jury Day Year)	28b. Time of Injury		8c. Injury Work			28d. Describe h	ow injury occur	red	
S	Attanding Ph er death. ector: After th by the funeral	cat	2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	he			М		′es 2□N	-				
Division of		ertification:	4 Homicide determine	d 28e. Place of I	njury - At h etc. <i>(Speci</i>		eet, factory	, office		2	28f. Location (S City or Tow		ber or Rura	l Route Number,
_	pital turs a aral I	O	00- 0-45							1/2				
	To the Hospital or within 24 hours afte to the Funeral Dir. completely filled in I	edicai	29a. Certifier 1 Dertifying F (Check only one) 2 Medical Exi	Physician: To the besaminer: On the basis	of examina	owledge, death ation and/or inv	occurred vestigation,	in my op	e, date and inion, deat	d place, a h occurre	and due to the o ad at the time, o	ause(s) and ma late and place,	anner as sta and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	and manner	stated.		290	. License	number			29d. Date signe	d (Month I	Day Year)
	⊢≯⊏8		1 (2)	100			, 4	> 1/1	6-20-	.0.				
•	d		1011111100	ic MV	alareste de	- 00-1 =),	119	707	15-7	V	U5.7	0 0	7
	2		Jon K. Lowe, HP.	2019 TIDEN		/ (1.	1100	of:	AIN	2140	2	
	Sta	te.	31. Date filed (Month, Day, Year)		trar's Signa	ature J	MA)][7]	meg 4	yns	, 11	2140	4	
1	Registr			2005	Diameter Comment	K L	ant s							

1 - For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Depai

Department of Health and Mental	Hygiene
Certificate of Death	6. U U
Certificate of Death	Reg. No.

	1796	0	0	
	1-1	11	7	1.
- 1	3 3	1.1	6	E.

3. Time of Death

8: 45AM

Physician		HENDY	MACK COLEY						2. Date of De Month	ath Day	200S	3. Time of Death
/Medica Examine		4a. Facility Name (If not institution	on, give street and number		1	4b. City, Town, or	r Location	of Death	11.00.4	4c. C	ounty of Death	<u> </u>
		SINAT			1	BA1-	.1	158			N/A	
Funeral Director		5. Social Security Number	6. Sex 7 1XXM 2□ F		last birthday)	If Under 1 Year Months Days	If Under Hours	Min.	Date of Bir (Month, Da	th ly, Yea <i>r)</i>	Cou	place (State or Foreig intry)
		240-44-2466 Usual Residence of Decedent			4				MAY 7	1931	NORTH	H CAROLINA
Maryland -f show lied at		10a. State 10b. County	у	10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limits
with the Marylan to cr 28e-1 show	2		N/A		BA	LTIMORE						XXYes 2 ☐ No
with tha	5	10e. Street and Number				10f. Zip Code				10g. Citize	n of What Cou	intry?
ms 23a mrs 23a mrs 23a	0	3902 MORTIMEI		et Francis II	10 10	212					.S.A.	
2 should be filed within 72 hours after death vand Mental Hygiene. Is marked other then "natural", or items 23s aumatic event, the Medical Exam actimust. To Be Completed by Finneral	5	1 XXVever Married 2 ☐ Mar	12. Was Deceder Armed Force 1. Yes 2	s?	1.3.	Was Decedent of Hi If Yes, specify Cuba	in, Mexicar	n, Puerto F	lican, etc.)	14.	. Race - Amer Black, White	
Pel'.o	, n	3 ☐ Widowed 4 ☐ Divorce	If Yes Give	s: 51/5	4	1 ☐ Yes 2ÃDNo	Specify:			S	pecify: BLA	ACK
dical	כוני	15. Deceder (Specify only highe	nt's Education est grade completed)		16a. Dece	dent's Usual Occupa	ation	t of workin	a	16b. Kind	of Business/Ir	ndustry
ygiene." natural. t, the Medical E.	2	Elementary/Secondary (0-12)	College (1-4c	or 5+)	life.	DO NOT use retired)		9	BALT	IMORE C	CITY DEPT
Hygie other ent, It		<u>unknown</u> 17. Father' <i>s</i> Name <i>(First, Middl</i> e,	(ast)		LABO	RER	19 Moths	aric Namo	(First, Middle,		rer	
Mental Arkad o atic eve	ו בֿ	MANSFIELD COI	•							Maldell Su	mame)	
umat T		19a. Informant's Name/Relations			19b. Mailir	ng Address (Street a			COLEY Route Numbe	er. City or T	own State Zi	n Code)
I fleath and Mental Hygiene. item 27 is marked other then "naturel", or items 23a or 28e-1 show other traumatic event, the Medical Exam retimation rediffied at To Be Completed by Finneral Director	1	Pernell M. Cole	ev/Son		1	CLIFTON						
Department of Health an Important: If item 27 Is any injury or other trau		20a. Method of Disposition XXBurial 2 Cremation		20b. F	Place of Dispo	sition (Name of matory or other place	e)	Da			tion - City or T	
Department Important: I any injury o once.		`4 ☐ Donation 5 ☐ Other (S	Specify)	10		CEMETERY	!)5 - 27-	-05	LANSI	OWNE.	MARYLAND
nport ny inj nce.		21. Signature of Funeral Service	Licensee		22	. Name and Addres	s of Facilit	v				
2 = e ol		galan	()		1	<u>206 W NOR</u>	JA HT	/ENUE			CAL HOM	E P.A.
₹.		23a. Part1. Enter the disease, o shock, or heart failure. List	only one cause on each	iline.								Approximate Interval Between Onset and Death
nysician Medical		Immediate Cause (Final disease or condition resulting in death)	a	OCA		al Ir	270	AS2 (Lion	١,		Onset and Death
Examiner			Due to (or a	as a conseq	uence of):							
e e		Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	as a conseq	uence oi):							
in and ial-transit Examiner		inat initiated events	с									
		resulting in death) Last	Due to (or a	as a conseq	uence of):							
he attending physician and ed for use as the burial-transit call for a second call call examir			d									
e attending physician and of for use as the burial-transit clary/Medical Examis		F FEMALE:	23c. If yes, outcom	ne of pregna	incv		199				1	
Bed for L		23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 4☐Pregnant	2 Fetal	Ideath 3□	Ectopic pregnancy Other (specify)				230	. Date of delive Month	ery Day Year
detacher		9 Unknown	9□ Unknown			.,,,,						
7 0	F	art II. Other significant condition	()	but not resi	<u> </u>		n in Part I.		23e. Did to	bacco use	contribute to the	he cause of death?
ate has been signed by the page 2 should be detached.	-	END STAGE	E Kena	1	Dist	ese			1 □ Y	es 2□N	lo 3 🗆 Prob	pably 4 Donknown
2 2 2	_	Hyperie	nsian						24a. Was a	an 2	4b. Were auto	psy findings available mpletion of cause of
cate he page page	1								perfor	med? 2 No	death?	2 No
ector, pag	ı	25. Was case referred to medica examiner?	Hospital:					of Death (Check only or	18)		
To dir	-	1 ☐ Yes 2 ☑ No 7. Manner of Death	1 Inpai		ER/Outpatient 28b. Time of		4 LI NUI				Other (Specify	y)
ector: After by the funer ification;	1	1 Natural 5 Pendir 2 Accident investi		ay Year)	Injury	28c. Injury Work' M 1 7	at ? ′es 2.⊟N		d. Describe h	ow injury of	ccurrea	
after death. Director: A J in by the fu		3 ☐ Suicide 6 ☐ Could	not be 28e. Place of Ir	njury - At ho	ome, farm, stre	eet, factory, office		28	f. Location (S.	treet and N	umber or Rura	l Route Number,
ed in by the funeral certification;		4 ☐ Homicide determ	building, e	etc."(Specify	/)	,			City or Town	n, State)		
10 m		29a. Certifier 1 Certifyin	ng Physician: To the bes Examiner: On the basis	of my know	wledge, death	occurred at the time	e, date and	place, an	d due to the c	ause(s) and	manner as st	ated.
the ple	- 1		and manner s	stated.	lion and/or inv			n occurred				
	2	9b. Signature and title of cortifie	1 01	•		29c. License		•			gned (Month,)	
	_	mod /	PNYSIC	- Av	<u>\</u>	000 9	5 Y S	28		May	25	2005
W.	5	0. Name and address of person	who completed cause of	death (Item	23a) (Type, I	Beller	1000	. A.	re Ra	1+.m	1000 1	2005
State		1. Date filed (Month, Day, Year)	TO POPE TO	trar's Signat	ture.	- 17/1/	er cr-c	011	7 13/7	£ 1111	-	0 = (-,)

DHMH 17 Rev 1/2001

State

Registrar

MAY 3 1 2005

32. egistrar's Signature

			4 15	partment of Health and Mertificate of Death		iene 0 0 5	18025
	Physici /Medic		1. Decedent's Name (First, Middle, Last) George William Depfer		2. Date of Death May 26,		3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and number) Manor Care Roland Park	4b. City, Town, or Location of Death Baltimore		4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday $214-20-8066$ 1% M $2 \square$ F 79 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, April 2	Year) 1,1926 9. Birthp Coun Mar	lace (State or Foreign try) yland
	Maryland -f show	tor	10a. State 10b. County 10c. City, Town or I			11	0d. Inside City Limits X1X□ Yes 2 □ No
	h with the 3a or 28a at be noth	al Director	10e. Street and Number 2005 Oakington Street	10f. Zip Code 21211	10	og. Citizen of What Coun	try?
980	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23a or 28a-1 show any fujury or other traumatic event, the Marifeel Erar, in ar mast be profited at ODGE.	by Funeral	3 ☐ Widowed 4 ☐ Divorced If Yes, Give WW⊥⊥ Year or Dates:	Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, o Specify: Whi	etc.
Maryland 21215-0036	within 72 ho lene. than "netui	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Dec (Giv (ifte.)) College (1-4or 5+) Too	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) 1 and Dye Maker	ing 1	166. Kind of Business/Ind	,
/land	uid be filed Mental Hyg Irked other Itic event,	To Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name			
	and 2 sho salth and 1 n 27 is ma		19a. Informant's Name/Relationship (Type, Print) Raymond Depfer Brother PO	ing Address <i>(Street and Number or Rura</i> BOX 4734 Baltimo:			
Baltimore,	Pages 1 ment of He ent: If iten ury or oth		4 Donation 5 Other (Specify) Lorraine	Park Cemetery	7	Woodlawn, Ma	aryland
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee Hense	2. Name and Address of Facility Burgee—Henss—Seitz 3631 Falls Road, Ba	Funeral	Home, Inc.	21211
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	the mode of dying, such as cardiac t	i lespiratory arres	51,	Approximate Interval Between Onset and Death
	/Medical Examiner	_	resulting in death) Due to (or as a consequence of): Sequentially list conditions,	· Comer in			
	xecuted and Il-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):				
68760,	ficate be executed physician and is the burial-transit	edical E	d				
P.O. Box (death certi	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	y Day Year
	sign sign	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to the	
Vital Records,	The ate h page	Completed			24a. Was an autopsy perform 1 Yes 2	prior to comed? death?	sy findings available inpletion of cause of
of Vit	Physicier this certif	: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 ☐ ER/O			nce 6 Other (Specify,	
Division of	To the Hospitel or Attending Physicien: white 24 hours after death. To the Funerel Director: After this certification the funerel director, to the funerel director, to mpletely filled in by the funeral director.	Certification:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)	Work? M 1 □ Yes 2 □ No		eet and Number or Rural	Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal (Check only one) 1 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a evestigation, in my opinion, death occurre	and due to the cau ed at the time, dat	use(s) and manner as sta e and place, and due to	ited. the cause(s)
,	To the complet	Me	29b. Signature and title of certifier	29c. License number D31464 Print) Swam 87 6	290	d. Date signed (Month, D	Pay, Year)
1	6		30. Name and address of person who completed cause of death (Item 23a) (Type SHOALLS A. WHI HARL, $82(N)$,	Print) Enlaw ST Fr	nte 308	Balt.	MD 51201
	Sta Registr		31. Date filed (Month, Day, Year) MAY 3 1 2005 MAY 3 1 2005	de s			

Physicia		For State Registrar		of Maryland / D	Certificate		_	Reg. No.	10020
Dungan		1. Decedent's Name (First, Midd					2. Date of De Month	ath Day Year	3. Time of Death
/Medic		Arthur Da	2iV				May.	26 2005	3:30 P M
Examin		4a. Facility Name (If not institution	n, give street and nu	ımber)	4b. City, T	own, or Location of De	ath	4c. County of Dea	th
		Greater Balti			Towso	n		Baltimore	
Funeral	a l	5. Social Security Number	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. last bin	thday) If Under 1 Yrs. Months	Year If Under 24 Hi Days Hours Mi	n. (Month, Da	y, Year) Co	thplace (State or Foreigi ountry)
Director		026-18-4267 Usual Residence of Decedent	1	83	TIS.		02/17	7/1922 PA	
* -	1	10a. State 10b. County	/	10c. City, Town	n or Location				10d. Inside City Limits
1 sho	ō	MD Balt	imore	Towson					1 ☐ Yes 2 ☑ No
28a-	Director	10e. Street and Number	Inore	TOWSOI	10f. Zip 0	Code		10g. Citizen of What Co	ountry?
Pa or		22 Dunvale Roa	a		212			United Sta	
ns 23	era	11. Marital Status		cedent Ever in U.S.		ent of Hispanic Origin?	(Specify Yes or No		
nd Mental Hygiene. marked other then "neturel", or llems 23a or 28a-1 show imetic event, It a Madical Examination that be institled at	Funeral	1 ☐ Never Married 2 ☐ Mar	Armed F		If Yes, specif	fy Cuban, Mexican, Pue	erto Rican, etc.)	Black, Whit	te, etc.
0	by	3 √Vidowed 4 □ Divorce	If Voe G	otes: WW II	1 🗆 Yes 2	Specify:		Specify: Wh	ite
etur	ted		nt's Education	16a.	Decedent's Usual	Occupation		16b. Kind of Business	
, g 2	ple	(Specify only night	est grade completed,	(1-4or 5+)	life. DO NOT use	done during most of w retired)	rorking	Commercial	/ Retail
giene er the	Completed	Elomoritary, 3000matry (5 12)	Comogo		les				
othe Vent.	Be	17. Father's Name (First, Middle,	, Last)			18. Mother's N	ame (First, Middle,	, Maiden Sumame)	
rked ric e	To E	Arthur John Da	vis, Sr.			Ruth I	Hasey		
and N is ma eume		19a. Informant's Name/Relation	ship (Type, Print)	19b.	. Mailing Address (Street and Number or I	Rural Route Numbe	er, City or Town, State, .	Zip Code)
f Health and Men item 27 is marke other treumetic		Jake Davis /So	n	9	848 Middl	Le Meadow R	oad Ellic	cott City,	MD 21042
		20a. Method of Disposition		camatai	Disposition (Name	e of ner place)	Date	20c. Location - City or	Town, State
Uepartment of Importent: If its any injury or o once.		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (1 State		ematoryInc	May 28 . 2005	Beltsville,	Maryland
inju	1	21. Signature of Funeral Service		,	22. Name and	Address of Facility			
		I found	4 / ha	rati		on and Fune		natives Baltimore, M	farvland 212
Medical caminer	nlner	resulting in death) Sequentially list conditions, if any, leading to immediate	b. G	(or as a consequence of the cons	· failure				
ysician and ne burial-trai	ical Examin	if any, leading to immediate cause. Enter unity Cause (Disease or injury that initiated events resulting in death) Last		onges five (or as a consequence of	heart t	allure			
by the attending physician and ached for use as the burial-transit	dical	that initiated events	d	utcome of pregnancy birth 2 ☐ Fetal death inant at time of death	heart to	gnancy		23d. Date of de Month	livery Day Year
attending for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 \(\subseteq \text{No} \)	23c. If yes, ou 1 Live 4 Preg	utcome of pregnancy birth 2 Fetal death nant at time of death	Leant (of): 3 □Ectopic pres	gnancy cify)			Day Year of the cause of death?
ate has been signed by the attending page 2 should be detached for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, ou 1 Live 4 Preg	utcome of pregnancy birth 2 Fetal death nant at time of death	Leant (of): 3 □Ectopic pres	gnancy cify)	1 ☐ \` 24a. Was	Month obacco use contribute to Yes 2 □ No 3 □ Po an 24b. Were al pror to death	Day Year of the cause of death? robably 4 □Unknown
ate has been signed by the attending page 2 should be detached for use as	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condit	Due to d. 23c. If yes, or 1 Live 4 Preg 9 Unkr	utcome of pregnancy birth 2 Fetal death nant at time of death	Leant (of): 3 □Ectopic pres	gnancy cify) use given in Part I. 26. Place of D	1 1 24a. Was autoperfo	Month obacco use contribute to Yes 2 No 3 Pr an 24b. Were a prior to death? 2 No 1 Yes	Day Year the cause of death? robably 4 Unknown utopsy findings available completion of cause of
iis certificate has been signed by the attending director, page 2 should be detached for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions the past 12 months with the past 12 months?	23c. If yes, or 1 Live 4 Preg 9 Unkr	utcome of pregnancy birth 2 Fetal death nant at time of death	Jeant for the underlying cau	gnancy cify) use given in Part I. 26. Place of D	24a. Was autor performed to the control of the cont	Month obacco use contribute to Yes 2 No 3 Pro an 24b. Were an prior to death? 1 Yes one) dence 6 Other (Spe	Day Year the cause of death? robably 4 □Unknown utopsy findings available completion of cause of
nis certificate has been signed by the attending director, page 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to d. 23c. If yes, or a contributing to define the contributing to define the contributing to define the contribution of	utcome of pregnancy birth 2 Fetal death nant at time of death nown death but not resulting in patient 2 FeVous of Injury 28b. 1	Jeant for the underlying cau	gnancy cify) use given in Part I. 26. Place of D	24a. Was autop performed 1 Yes eath (Check only of the 28d. Describe I	Month obacco use contribute to Yes 2 No 3 Pr an 24b. Were a prior to death? 2 No 1 Yes one) dence 6 Other (Spe how injury occurred	Day Year the cause of death? robably 4 □Unknown utopsy findings available completion of cause of 2 □ No
iis certificate has been signed by the attending director, page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions are referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendi invest 2 Accident 3 Suicide 6 Could	Due to d. 23c. If yes, or 1 Live 4 Preg 9 Unkritions contributing to 6 al Hospital: 1 28a. Date (Morigation Inot be right) 28e. Place	utcome of pregnancy birth 2 Fetal death name of death nown death but not resulting in a second control of linjury 28b. The second control of linjury 28b. Th	Jeant (special stream) 3 Ectopic pressure of the underlying cause of the unde	gnancy city) 26. Place of D Other: 4 Nursing c. Injury at Work? 1 Yes 2 No	24a. Was autop performed 1 Yes eath (Check only of the 28d. Describe I	Month obacco use contribute to Yes 2 No 3 Pro- an 24b. Were an prior to death? 1 Yes one) dence 6 Other (Spechow injury occurred	Day Year the cause of death? robably 4 □Unknowr utopsy findings available completion of cause of 2 □ No
is certificate has been signed by the attending director, page 2 should be detached for use as	edical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions are referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendi invest invest 3 Suicide 6 Could detern	Due to d. 23c. If yes, or a contributing to design the contribution of	utcome of pregnancy birth 2 Fetal death nant at time of death nown death but not resulting in the property of Injury and Pay Year) 28b. The property of Injury At home, faing, etc. (Specify)	Jeant (specific pressure states and states and states are states as a second state and states are states as a second state are states are states as a second state are states as a second stat	gnancy city) 26. Place of D Other: 4 Nursing c. Injury at Work? 1 Yes 2 No office	24a. Was autop performed to the control of the cont	Month obacco use contribute to Yes 2 No 3 Pro- an 24b. Were an prior to death? 1 Yes one) dence 6 Other (Spechow injury occurred	Day Year to the cause of death? robably 4 □Unknown utopsy findings available completion of cause of 2 □ No crify) ural Route Number,
iis certificate has been signed by the attending director, page 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE. 23b. Was decedent pregnant in the past 12 months? 1	Due to d. 23c. If yes, or a contributing to design the contributing to design the contributing to design the contribution of	utcome of pregnancy birth 2 Fetal death pant at time of death nown death but not resulting in the part of Injury anth, Day Year) 28b. The part of Injury At home, fairing, etc. (Specify) The best of my knowledge basis of examination and	tpatient 3 DOA time of njury M m, street, factory, a, death occurred at d/or investigation, i	gnancy cify) 26. Place of D Other: 4 Nursing c. Injury at Work? 1 Yes 2 No office t the time, date and pla n my opinion, death oc	24a. Was autop performed at the time,	Month obacco use contribute to the contribute t	Day Year to the cause of death? robably 4 □Unknown utopsy findings available completion of cause of a 2 □ No crify) ural Route Number, s stated, to the cause(s)
iis certificate has been signed by the attending director, page 2 should be detached for use as	edical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to d. 23c. If yes, or a contributing to design the contributing to design the contributing to design the contribution of	utcome of pregnancy birth 2 Fetal death pant at time of death nown death but not resulting in the part of Injury anth, Day Year) 28b. The part of Injury At home, fairing, etc. (Specify) The best of my knowledge basis of examination and	tpatient 3 DOA time of njury M m, street, factory, a, death occurred at d/or investigation, i	gnancy cify) 26. Place of D Other: 4 Nursing c. Injury at Work? 1 Yes 2 No office	24a. Was autop performed at the time,	Month obacco use contribute to the contribute t	Day Year to the cause of death? robably 4 Unknown utopsy findings available completion of cause of 2 No cify) ural Route Number, s stated. a to the cause(s)
is certificate has been signed by the attending director, page 2 should be detached for use as	edical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to d. 23c. If yes, or a contributing to design the contribution to the contribution to the contribution of	utcome of pregnancy birth 2 Fetal death pant at time of death nown death but not resulting in the part of lingury of lingury of lingury. At home, far ding, etc. (Specify) are best of my knowledge basis of examination and sing of death (Item 23a) (see of death (Item 23a) (see of death (Item 23a))	tpatient 3 DOA transport of the underlying cau ttpatient 3 DOA transport of the underlying cau ttpatient 3 DOA transport of transport of the underlying cau ttpatient 3 DOA transport of transport of the underlying cau trans	gnancy cify) 26. Place of D Other: 4 Nursing c. Injury at Work? 1 Yes 2 No office t the time, date and pla n my opinion, death oc License number	24a. Was autop performed to the coursed at the time,	Month obacco use contribute to the contribute t	Day Year to the cause of death? robably 4 Unknown utopsy findings available completion of cause of 2 No wrify) ural Route Number, s stated, a to the cause(s)

			1 - For State Registrar	tate of Maryland / D	epartment of H Certificate of L		ental Hygiei Reg.	2000	18027
	Physici /Medio	cal	Decedent's Name (First, Middle, Last) A A A A A A A A A A A A A A A A A	WR FNCE	D UCF	Location of Death	RAY Z	Day Year 3 2003	3. Time of Death
	Examin Funeral Director	ier	# 4 MOV M 1 B A 7 5. Social Security Numberunk 6. Sex 1 反 M	TEN CouRT 7. Age (In yrs. last birth	Wood	If Under 24 Hrs. B	Date of Birth	SAIFIN ar) 9. Birth Cou	place (State or Foreign or Land
	th the Maryland or 28a-f show s natified at	Director	Usual Residence of Decedent 10a. State 10b. County MD 10e. Street and Number	10c. City, Town	or Location timore				10d. Inside City Limits 1
036	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "neturel", or items 23e or 28e-f show event, the Medical Evarrinal must be neilified at	by Funeral	1 ANever Married 2 Married	rt #102 Nas Decedent Ever in U.S. Armed Forces? I □ Yes 2 ♥ No fyes, Give Year or Dates:	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	21207 spanic Origin? (Specin, Mexican, Puerto Ri	fy Yes or No- can, etc.)	USA 14. Race - Americ Black, White, Specify: b1	
21215-0036	filed within 72 hou Hygiene. other than "neture ent, the Wedical E	Completed	12	mpleted) College (1-4or 5+)	Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired, rniture asse	during most of working embler	n	. Kind of Business/Ir nanufactur	,
Maryiand 2	should be fill not Mental Himarked oth	To Be	17. Father's Name (First, Middle, Last) Richard Duckett			18. Mother's Name (First, Middle, Maid Roberts	len Sumame)	
	as 1 and 2 should by Health and Ment litam 27 is marked rother traumatic e		19a. Informant's Name/Relationship (<i>Type</i> , Mark Strand/brothe)		Mailing Address (Street a				21223
Baitimore,	Page ment ent: if ury o		20a. Method of Disposition 1 Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify) 1	n state cemetery	Disposition (Name of c, crematory or other place	 		Location - City or To	
g	permit. Departimonto		21. Signature of Euneral Arvice Licensee Ronald S. Wa.	1/10	22. Name and Address State Anato Baltimore,	MD 21201		altimore S	Approximate
8/60,	death certificate be executed National physician and eattending physician and for use as the burial-transit	dical Examiner	shock, or heart failure. List only one commediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	ause on each line.	Soord 7	to Ken	3		Interval Between Onset and Death
O. Box 6	death certiff e attending id for use as	Physician/Med	in the past 12 months?	f yes, outcome of pregnancy Live birth 2 Fetal death Pregnant at time of death Unknown	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delive Month	əry Day Year
rds, P	requires that the de een signed by the a hould be detached f	by	Part II. Other significant conditions contrib	uting to death but not resulting in	the underlying cause give	on in Part I.	1	o use contribute to to	he cause of death?
аі несога	The law ate has b page 2 sl	Completed					24a. Was an autopsy performed 1 Yes 2 12	prior to co death?	psy findings available mpletion of cause of 2 \(\square\) No
Division of Vital	inding Physath. r: After this ie funeral di	ertification; To Be	1 Natural 5 Pending investigation	8a. Date of Injury (Month, Day Year) 8. PI ce of Injury - At home, fan building, etc. (Specify)	jury Work O C C M 1 □ Y	at 28. /es 2 ANo	5 PResidence d. Describe how in f. Local on (Street City or Town, St	and Number or Rura ate)	TE) al Route Number,
-ad	To the Hospitei or Atte within 24 hours after de To the Funerel Diracto completely filled in by th	ledical Co	29a. Certifier (Check only one) 29 Medical Examiner:	m: To the best of my knowledge, On the basis of examination and and manner stated.	death occurred at the tim for investigation, in my op	e, date and place, and inion, death occurred	d due to the cause	(s) and manner as s and place, and due to	tated.
	To th within To th сощр	Me	29b. Signature and title of certifier 30. Name and address of person who compl	Man I M	29c. License		29d. [Date signed (Month, AY 25,	2065
	Sta Registr	- 4	31. Date filed (Moore, Data) Pari)2005	4 2 So V 1 3 42. Registrar's Signature	93355	OANSLA	TWE E	LLICOT	2005 TC,54

State of Maryland / Department of Health and Mental Hygiefie | | 5 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Andrew P. Epifanio Month Yee MAY 5:04F M 26, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Saint Joseph Medical Center Towson Baltimore 8. Date of Birth (Month, Day, Year)
Aug. 12, 1932 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral X**XM 2□ F Days Hours Director Yrs 72 Maryland 218-28-8825 Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show treumetic avant, the Madical Examiner must be notified at XX Yes 2 No N/A Baltimore Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 412 Fawcett Street 21211 USA or Itams 23e death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② XXNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, e filed within 72 hours after de Il Hygiene. othar than "natural", or Itam Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes XX No Specify: þ 3 ☐ Widowed 4 1 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Machinery Worker Metal Parts Production othar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f nent of Health and Mental I int: If itam 27 Is markad of John Epifanio Elizabeth ပ Buono 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If itam 27 Is any injury or othar tret once. Son 2821 Nestor Court Bowie. Maryland 21716 Scott Epifanio 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State New Cathedral Cemetery 5/31/05 | Baltimore, Maryland ` 4 ☐Donation 5 ☐ Other (Specify) 21. Signatur of Frineral Service License 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21211 23a. Part1. Enter/the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) SEPTIC SHOCK /Medical Due to (or as a consequence of) Examiner PERITONITIS STATUS POST SECOND DEGREE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last BOWEL PERFORATION Due to (or as a consequence of): Box 68760. Physician/Medical METASTATIC ADENOCARCINOMA STOMACH IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. the 9□ Unknown à signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by RESPIRATORY FAILURE No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? RENAL FAILURE 24a. Was an page 2 autopsy perform Yes 2 1 Yes 2 No Yes Hospital or Attending Physicien: director, 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 X Natural 2 ☐ Accident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours af To the Funerel D Decrifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifie 2 29c. License number 29d. Date signed (Month, Day, Year) D24034 ress of person npleted cause of death (Item 23a) (Type, Print) 30. Name and add 76 (21 OS) 32 Registrar's Signature TIMOTHY LOW M. I 31. Date filed (Month, Day, Year) MAY 3 1 2005 OSLER DRIVE TOWSON, MARYLAND 21204 State

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY 16 2005 **Physician** ERICHSEN BRODER MAYNARD 7:17 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER MONTGOMERY BETHESDA If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1XM 2□F Months Days Hours Min. 550-42-2695 Director 81 1923 Dec. 6, Maryland Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at 1 X Yes 2 No Directo Virginia Fairfax Herndon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3421 West Ox Road 20171 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?

1 XYes 2 No6 / 25 / 58 Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene.
Is marked other than "natural, or iter 1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 7/1/69 þ Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronics Warfare Analyst Defense Systems 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental ent: if item 27 is marked o Broder P. Erichsen Cora Etta Huff 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3421 W. Ox Rd., Herndon, VA 20171 Virginia Erichsen (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State = 5 permit. Page Department of Importent: If any injury or Metropolitan Crematory 5/27/05 Alexandria, VA ⁴ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses (22. Name and Address of Facility Mission Park Funeral Chapels 1700 Southeast Military Dr., mi lennis San Antonio, TX 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last h. Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes XNo 3 Probably 4 Unknown page 2 should Completed peeu 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1√ Yes 2 🗆 No 1 Tyes Hospitei or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 ☐ Yes 2 ☐ X 100 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Injury 1 Katural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 🕉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certified

M.P.MCNALLY

MAY 3 1

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

MC

USN

egistrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

back!

29c. License number

0101228422 (VA)

BETHESDA MD

29d. Date signed (Month, Day, Year)

NATIONAL NAVAL MEDICAL CENTER

20889-5600

2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Eddie 2 By **Physician** toste 23:21PM lames 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ORR - 6958 If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** -60-1**X** M 2 Hours Days **Director** Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits item 27 is marked other than "neturel", or Items 23e or 28e-f show other traumatic event, the Medical Exame er must be notilised at 1 Pres 2 No ti more **Funeral Director** 10f. Zip Code 21207 10e. Street and Number 10g. Citizen of What Country? 06 death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Married Yes 2 Yes, Give 2 No 1 Never Married 1 ☐ Yes 2 XNo Specify: 2 4 Divorced Blac 3 Widowed ear or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. Demot use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Fainer's Name (First, Middle, Last) other's Name (First. mnie 19a. Informant's 19b. Mailing Addr s (Street and Number or Rule) Name/Relationship (Type 21207 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location Burial 2 Cremation 3 Removal from State Ponation 5 ☐ Other (Specify) nature of Fugeral Service Licent town, MU ZIB3 Approximate Interval Between Onset and Death 12 yeur 23a. Part1. End the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or weart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) therosclerat Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of), Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): P.O. Box 68760 the attending physician Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy be detached for Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Illnknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wasan autopsy performed 2 No 1 Yes or Attending Physician: Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 🖺 ER/Outpatient 3 🛣 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pendina investigation 1 Tes 2 No within 24 hours after death To the Funeral Director: 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospitel 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License number 20 9 30. Name and address of person who ompleted cause of death (Item 23a) (Type, Print) St. Agnes

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

00/c01

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 5

1803

				Certificate of Death	- 1	Reg. No.						
	· ·		Decedent's Name (First, Middle, Last)		2. Date of Dea	ath Day Year	3. Time of Death					
	Physici /Media		Robert J. Jeeley		5	17 2005	5 6 AM					
	Examir	**	4a Facility Neme (If not institution, give street and number)	4b. City, Town, or Lo	1	. \	- 1					
			vantage House	Colum	bia	Howa						
Ç	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bit	thday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birt (Month, De	y, Year) 9. Birthp	lace (State or Foreign stry)					
	Director		115-24-7672 102 M 2 U F 85		June 9,	1919 New	York					
	land		10a. State 10b. County 10c. City, Tow	n or Location		1	0d. Inside City Limits					
	Mary	ច	Maryland Howard Colu	mhia			1 ☐ Yes 2 💢 No					
	128a	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Cour	ntry?					
	nurs after death with the Manylan al', or items 23e or 28a-f ahow Examiner must be notified at		5400 Vantage Point Road	21044		U.S.A.						
	me 2	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	- 14. Race - Americ						
0	after or fte		1 □ Never Married 2 □ Married 1 ☒ Yes 2 □ No 11/13/	42 1 □ Yes 2 ▼ No Specify:	riioari, etc.)	Black, White,						
02	rai',	by	3 Widowed 4 □ Divorced Year or Detes: 02/22/	46		Specify. White	2					
Maryland 21215-0020	within 72 hours after death with the Maryland ene. than "natural, or items 23e or 28a-f ahow ha Medical Examiner must be indified at	Completed	15. Decedent's Education 16a (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing	16b. Kind of Business/Inc	dustry					
121	ithin	Ę.	Elamentary/Secondary (0-12) College (1-4or 5+)			Dubliahiaa (2					
2	filed withi Hygiene. Ither than	Ŝ	17. Father's Name (First, Middle, Last)	Sales Manager		Publishing (company					
an S	o is b	Be				Welder Carrette						
ž	should be ind Mental i merked o umetic ev	ဥ	Patrick Feeley 19a. Informant's Name/Relationship (Type. Print) 19t	Estelle D. Mailing Addrass (Street and Number or Run		or City or Town State Zin	Codel					
Z	O 00 00 00	- 1					0000)					
	1 and 2 Haalth em 27 i		20a Method of Disposition 20b. Place of	5 Purdy Ct., Rockvill f Disposition (Name of	Date	20c. Location - City or To	wn, State					
ē	Pages net of int: if its iry or o		1 Burial 2 ☐ Cremation 3 ☐ Removal from State	rton National Cemeter	/19/05	Calverton,	NY					
Baltimore,	parmit. Pages Department of Important: If it any injury or once.		4 □ Donation 5 □ Other (Specify) Calve:		-		111					
Ba	parmit. Departmimportal any inju		I I I I I I I I I I I I I I I I I I I	22. Name and Address of Facility Edward F. Lieber			NT 11500					
_			23a. Part1. Enter the disease, or complications that caused the death. Do	266 N. Central Av	re., Val	ley Stream,	NY 1158U Approximate					
4	Dharaisian		shock, or heart failure. List only one cause on each line.	not onto the mode of syring, each as all all			Interval Between Onset and Death					
i.	Physician /Medical		Immediate Cause (Final	= 1 11 - 0 .								
	Examiner		Immediate Cause (Final disease or condition resulting in death) a. Arel 5671e450 V. Due to (or as a consequence of):									
		Je.	Sick Son	2 6- 20 d x	DA - 0							
	cate ba axecuted physician and s the bunal-transit	Examiner		consequence of):								
oʻ	an ar	Ä	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	j								
68760,	ysici	Ca	that initiated events resulting in death) Last									
39 ×	entifica ding ph se as t	Medicai	Pa Meine	on's Disea	SP							
B 0)	law requiras that tha death certificate be assecuted as been signed by the attanding physician and as been signed by the attanding bhysician and second be detached for use as the bunal-transit											
0	at tha dea by the a stached f	Physician	Part II. Other algnificant conditions contributing to death but not resulting it	n the underlying cause given in Part I.	23b. Did 1	tobacco use contribute to	the cause of death?					
σ.	that the ed by datac		Dementie		1 🗆 '	Yes 2□No 3□Pro	bably 4 Tunknown					
ds,	uiras t signe Id be	d b			24a. Was	an autopsy 24b. W	ere autopsy findings					
Ö	requ been shoul	ete	PSycholis		perfo	rmed? av	ailable prior to mpletion of cause death?					
Vital Records,	0 - 0	Completed	0 1 1	2 0 0 0 0 0 0	101	,	Yes 2 No					
a	Ician: The cartificate h		25. Was case referred to medical	26. Place of Deat			7162 21310					
<u>=</u>		o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/O	Other:		dence 6 Other (Specif	Retiremen					
ō		\vdash	27. Menner of Death 28a. Date of Injury 28b.	Time of 28c. Injury at		how injury occurred	How					
Ö	Attending I or death. Octor: Aftar by tha fune	atio	1 ☑Naturel 5 ☐ Pending (Month, Dey Year) 2 ☐ Accident investigation	Injury Work? M 1 Yes 2 No								
Division	or Attendia after death. Director: A	III	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, factory, office	28f. Location (S City or Tox	Street and Number or Rura vn, State)	I Route Number,					
Ö	tal or A	Certification:			•							
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in the	edicai	29a. Certifier (Check only 2 ■ Medical Examiner: On the basis of examination ar									
	the the mplet	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month,	Dav. Year)					
	5 <u>\$</u> 5 <u>9</u>	_	b/)	2111		1-1-1						
		r	20 Name and address of passed the completed source of death (how 22)	(Type Print)		7/11/07						
1	20		30. Name and address of person who completed cause of death (Item £3a)	MAN TO ONE AN	Colon	Chile and	21207					
	Sta	ate	31. Date filed (Month, Day, Year) 32. Refistrar's Signature	in his conjust its,		34110						
	Registi		MAY 3 1 2005	Sparke								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 23, 2005 Eleanor M. Floyd 20:30 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Health Center Belair, MD Harford If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 212-20-2807 1 □ M 2 🖸 F 80 Yrs. March 1,1925 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Harford Belair 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 522 Thomas Run Rd 21015 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2XXIIIO If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ZNo Specify: 3XXVidowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Secretary Post Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas Vail Catherine Mallonee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta L. Myer / Daughter 392 Centerhill Avenue, Linthicum Heights MD 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Holy Cross Cemetery 05/26/05 *4 ☐ Donation 5 ☐ Other (Specify) Baltimore Maryland 21. Signature of Funeral Service LicenseeVictor P. Doda, Jr 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 East Fort Avenue, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Severe Acidosis 3 Days Failure Organ 4 Days Severa 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

Vital

of

Division

Physician

/Medical

Examiner

Director

Be

၉

Funeral

Director

Sequentially list conditions, the peaking to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Be

2

Certification:

Medical

in the past 12 months? 9 Unknown

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

Hospital: 1 ☑npatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Pending investigation

28b. Time of Injury

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

2 No

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29c. License number

D0053568

5/24/05

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeffrey A. Thompson, MD, 500 Upper Chesapeake Drive Bel Air, MD 21014
31. Date filed (Month, Day, Year)

82. Registrar's Signature

State Registrar

To the Hospitel or Attend within 24 hours after death To the Funerel Director:.

MAY 3 1 2005

6 Could not be determined



			For State	State of Maryla I #16a&b&19a PE	-			Mental Hy	giene Reg. No		18033	
	Dhysiai	an.	Decedent's Name (First, Middle,		R PH GO			2. Date of De		y Yeer	3. Time of Death	
3	Physici /Medio	al	MARIAN 4a. Fecility Name (If not institution,	give street and number		1	SCHELL or Location of Deat	1 . 1	20	200 S		
	Examir	ier	JOHNS HOPKIN			40. Oily, Town,	BALTI		10.			
	Funeral Director		051-24-9931	10 H 10 F	rs. last birthday) 74 Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da JUN. 19	th y, Year) 1,193	9. Bir	thplace (State or Foreign ountry) NY	
	ow ot		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation					10d. Inside City Limits	
	e Many Sa-f sh	Director	MD HOWARD DAYTON								1 Yes 2 No	
	with th	Dire	10e. Street and Number 14600 VIBURN	IIM DRIVE		10f. Zip Code	21036		10g. Cit	izen of What Co	•	
	ems 2	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of f Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puer	pecify Yes or No o Rican, etc.)	D-	14. Race - Ame Black, Whi	erican Indian,	
980	be filed within 72 hours after death with the Maryland lat Hygiene. Id other than "natural", or Items 23a or 23a-1 show other than "natural" to reminer must be notified at event, the Mcdiest Examiner must be notified at	by	1 ☐ Never Married 2 💢 Marrie 3 ☐ Widowed 4 ☐ Divorced			1□Yes 2🎇 No				Specify:	WHITE	
15-0	n 72 ho "natur	leted	15. Decedent' (Specify only highest	t grade completed)	16a. Deced (Give	dent's Usual Occu kind of work done DO NOT use retin	upation e during most of wo	rking	16b. K	ind of Business	Vindustry	
212	d withii giene. er than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			EACHER		ME	DICAL E	DUCATION	
and	ed ta b y	Be	17. Father's Name (First, Middle, L MORRIS	ast)	STA	NDARD	18. Mother's Nar	ne (First, Middle	, Maiden	Sumame)	WALDMAN	
Baltimore, Maryland 21215-0036	2 should be filed withir and Mental Hygiene. Is marked other than sumatic event, the Mental than the Mental the Mental than th	Jo	19a. ROBER Hame Relationsh		19b. Mailir	ng Address (Stree	at and Number or Ru		-		Zip Code)	
e, R	1 and Health Iem 27		ROBERT FISCH 20a. Method of Disposition		b. Place of Dispo	sition (Name of	RNUM DRIVE	Date DAYT		MD 2103 ocation - City or		
E I	Pages nent of I int: If its		1 ☐ Burial 2 🔏 Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 □Removal from State H		ERVICE (ORP. 05/2	27/2005		TOWSON,	MD	
Balti	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other traumatic once.		21. Signature of Funeral Service L	icensee (1#14)	1	Name and Addi	STERSTOWN	SOL LEVI				
2	\$,	П	23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caused the d						LOVILLE	Approximate Interval Between	
	Physician /Medical		Immediete Cause (Final disease or condition resulting in death)	a	MONI	A					Onset and Death	
7	Examiner			sequence of):	MYELVID LEUKEMIA					2 YEARS		
	De is	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a cons	Due to (or as a consequence of):							
di.	execution and ial-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a cons	sequence of):	quence of):						
68760,	ficate be executed physician and s the burial-transit	edical	Į.	d						***************************************		
Вох 6	death certific a attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre						23d. Date of delivery		
.O.	Physician: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use a	Physician/M	in the past 12 months? 1 □ Yes 2 ⊠No 9 □ Unknown	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown		Ectopic pregnan Other (specify)	cy .			Month	Day Year	
S, P	uires that signed b d be deta	by Pt	Part II. Other significant condition	ns contributing to death but not	resulting in the u	nderlying cause g	iven in Part !.			2	o the cause of death?	
ord	w require been si should l	eted						24a. Was			robably 4 Unknown utopsy findings available	
Rec	The law te has age 2 s	Completed						auto		prior to death?	completion of cause of	
/ital	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?					ath (Check only				
of \	Physic rthis or ral dire	ို	1 ☐ Yes 2 No 27. Manner of Death		2 ER/Outpatier	I 3L DUA		lome 5 ☐ Resi			ecify)	
ion	ath. rr: Afte	atlor	1 X Natural 5 Pending 2 Accident investig	ation	r) Injury	M 28c. Inju	ork? ⊒Yes 2⊡No			mary occurred		
Division of Vital Records, P.O.	or Attending after death. Director: After din by the fune	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	9	28f. Location (City or To			ural Route Number,				
	Hospita 24 hours Funeral	Medical C	29a. Certifier 1 Certifying (Check only 2 Medical E	g Physician: To the best of my Examiner: On the basis of exam and manner stated.	knowledge, death nination and/or in	n occurred at the vestigation, in my	time, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and manner a d place, and du	s stated. e to the cause(s)	
_	To the within 2 To the complet	Med	29b. Signature and title of certifier	A A		29c. Licer	se number		29d. Da	te signed (Mon	th, Day, Year)	
	/		tallet	shr-el-		R	ES-00	0	MA	y 26	2005	
	5		30. Name and address of person of MALLAR BH	who completed cause of death (IULFE STRE	ET RAIT	FIMOR	RE, MAR	YLAND 21287	
	Sta	ate	31. Date filed (Month, Day, Year)	82. Registrar's Si					- 1-1			

			For State Registrar	State of Maryla		artment of H		_	ene (105	18034
			Decedent's Name (First, Middle, La	st)			2. Date of Death	e of Death 3. Time of			
	Physici		Joseph Gau	779			Month May	Day L8.	Year 2005	4:30 A M	
	/Medic Examir		4a. Facility Name (If not institution, giv	4b. City, Town, or	пау .		unty of Death	4:30 A			
	=		7400 Locust Dr.			Hanove	r		Anne	Arund	e1
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yi	s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth			lace (State or Foreign
	Director		215-14-6949	X M 2□ F 96	Yrs.	Months Days	Hours Min.	(Month, Day, 10/26/19			ington. DC
	D .		Usual Residence of Decedent					10/20/1	700	- Masu	rugron, DC
	urylar show	_	10a. State 10b. County	10c.	City, Town or Lo	cation				1	0d. Inside City Limits
	Ba-f s	Director	Maryland Prince	George's	Laure1						XXYes 2 No
	or 28)ire	10e. Street and Number			10f. Zip Code		10	g. Citizen	of What Coun	itry?
	23a		9000 Bryer Croft	Lane		207	08		U.S	.A.	
92	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Eventiest must be notified at	y Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 Yes 2 You		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes XX No	spanic Origin? (Spe n, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14.	Race - Americ Black, White, ecify:	
21215-0036	uraľ	d by	3 Navidowed 4 □ Divorced	Year or Dates: WWI	I					Whi	
7	"nat	Completed	15. Decedent's E (Specify only highest gra		(Give	ient's Usual Occupa kind of work done d	uring most of working	ng 1	6b. Kind	of Business/Ind	dustry
12	vithir no. han	du	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired)	,				
	filed v Hygie other t		17. Father's Name (First, Middle, Last,		Раре	rhanger	40 Made de Norse			paperin	ng
anc.	be find half	Be					18. Mother's Name			name)	
<u> </u>	should be filed within and Mental Hygiene. marked other than imatic event, the Mental than the matic event.	ပို	Joseph P. Gauzza					obtainab			
Maryland	12 sho		19a. Informant's Name/Relationship (19b. Mailir	ng Address (Street a	nd Number or Rurai	Route Number,	City or To	wn, State, Zip	Code)
	1 and 2 Health tem 27 l		Thelma Gore/Siste	r-in-law	7400	Locust Dr	. Hanover				
altimore,	ges t of h if ite		1 X Burial 2 Cremation 3		cemetery, crer	sition (Name of natory or other place	9)		0c. Locati	on - City or To	wn, State
Ē	men tant: jury		`4 ☐Donation 5 ☐ Other (Specif			coln Cem.	5/25/			wood, 1	1D
Ba	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other ODG8.		21. Signature of Funeral Service Light	nsfe P			s of FacilityFort sburg Rd.				22
			23a. Part. Enter the disease, or com shock, or heart failure. List only	plications that caused the de	ath. Do not ent	er the mode of dying	, such as cardiac or	respiratory arres	st,		Approximate Interval Between
	Pnysician ·		Immediate Cause (Final								Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a cons		HEART	FAILUR	Ŀ-			SYEARS
P	Examiner			PANCYTO		<i>A</i>				-	MONTHS
		e	Sequentially list conditions, I any, loading to immediate	b. Una to (or se a none		77					L 17614 7173
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	DIABETE	= <						O YEARS
<u>,</u>	n an ial-tra	Еха	resulting in death) Last	Due to (or as a conse							30 /27/13
8760,	icate be executed physician and s the burial-transit	dical		d							
.89			0.000	V							
Вох	death certifi e attending od for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg	nancy				23d.	Date of delive	rv
ă	death atte	cia	in the past 12 months?	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of		Ectopic pregnancy Other (specify)			1		Day Year
Р. О.	that the de led by the a detached f	ysi	9 Unknown	9□ Unknown							
	The law requires that the tee has been signed by thoage 2 should be detache	y P	Part II. Other significant conditions of	ontributing to death but not re	sulting in the ur	nderlying cause give	n in Part I.	23e. Did toba	cco use c	ontribute to the	e cause of death?
g	uires sign							1 ☐ Yes	2 N	3 Proba	ably 4 Unknown
Records,	w requir been s should	Completed						24a. Was an	24	Ib Mose sutos	our findings available
Re	has ge 2	m						autopsy		prior to con death?	ssy findings available apletion of cause of
			OS Was seen					1 ☐ Yes 2	No	1 Yes	2□ No
Division of Vital	Physician: The la this certificate had ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:		Othor	26. Place of Death				
o	<u>a</u> = <u>a</u>	. To	1 ☐ Yes 2 🔀 No 27. Manner of Death	1 ☐ Inpatient 2	☐ ER/Outpatien 28b. Time of	t 3 DOA 28c. Injury	4 Nuising nom	e 5 Residen 3d. Describe how)
L _O	ding I h. After funer	lo	1 X Natural 5 ☐ Pending	(Month, Day Year)	Injury	Work'	es 2 □ No	od, Describe now	anjury oc	curred	
S	deat deat ctor: / the	ica	2 Accident investigation 3 Suicide 6 Could not be	9	home farm etr			of Location (Stre	at and Ni	mbos os Bural	Pouto Mumbos
<u>></u>	al or Attend after death Director: / d in by the f	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	cify)	eet, ractory, office	20	3f. Location (Stre City or Town,	State)	imber or Hurai	Houte Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Ph	veicien: To the heat of mustin	Towlades door	Opposed at the co	n data cod of	and observed at the	20/2)		
	Hos 24 hr Fun stely	Medical	(Check only one)	ysicien: To the best of my kinner: On the basis of examinand manner stated.	nation and/or inv	estigation, in my opi	e, date and place, ar inion, death occurre	io due to the cau d at the time, date	se(s) and e and plac	manner as sta ce, and due to	tted. the cause(s)
	ithin o the	Me	29b. Signature and title of certifier	and mailler stated.		29c. License	number	200	I Date sin	ned (Month, D	Day Year)
	F 3 F 8		& S. Aujan	at MA							-
•	/		-				15558	C	J ~	25-2	00>
	4	H	30. Name and address of person who								
			S.C. ARYANGA	77, MD 33	OS PEA	CRY STRE	EET, Mr	RAINIE	R,	MD 2	6783
	Sta Registr	_	31. Date filed (Month, Day, Year)	32 Registrar's Sign	Iature	Mary .					
	riegisti		MAY 3 I Z	103 Charles	No.						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Ann May 29. 2005 /Medical 11:50pm 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 226 Hazel Ave. Lansdowne Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 1 □ M 2√€ F Director 395-56-4795 52 Sept. 18, 1952 Wisconsin Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ehow the Medical Exercitor rought by notified at Director 1 ☐ Yes 2 ☐ No Baltimore Lansdowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or Itams 23a 226 Hazel Ave. 21227 death Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by white Specify: 3 → Widowed 4 Divorced white Year or Dates: natural. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Business Owner other t Tavern permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stephen C. Luedtke ပ Dorothy Schanowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Corinne E. Kemp--Daughter 226 Hazel Ave., I anslowne, Maryland 2127

20b. Place of Disposition (Name of cametery, crematory or other place)

I anslowne, Maryland 2127

Date 2 c. Location - City or Town, State 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery June 4, 05 Maltimore City 21. Signature of Funeral Service Vicensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. BAltimore, Maryland 21229 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician ancreatic cancer months resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical as ed by the attending detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown ۵ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2 **1**No 3 Probably 4 Unknown as been si 2 should Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No certificate ha autopsy performed 1 Yes 2 No Hospital or Attanding Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after deat To tha Funaral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 - Homicide .⊆ 1 Lartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) the 29b. Signature and title of certifier To 29c. License number 29d. Date signed (Month, Day, Year) PHYSICIAN 053590 MAY 31,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 624 NORTH BROADWAY DY BALTIMORE 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State MAY 3 1 2005 Registrar

		1 - For State Registrar 1. Decedent's Name (First, Middle, La		Marylar		artment of rtificate o	Health and of Death		Reg. No.	005	- C - C - C - C - C - C - C - C - C - C	36
Physici		Thelma	131)		Gora	spe		2. Date of I	Day	2005	3. Time of 1	
/Medic Examin		4a. Facility Name (If not institution, gire	e street and numb	oer)			n, or Location of Dea	may	4c. C	ounty of Death	6.01	
		The Johns Ho	pkins :	Hoop.	ital	Ba	Himory	٩ سـ	,	,		
Funeral Director		5 Social Security Number 6 5		Age (In yrs.	(ast birthday)	If Under 1 Yes		8. Date of E	Birth Day, Year) -42	9. Birth	place (State or ntry)	Foreign
and		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	ncation						. 1 7 - 7 -
ith the Marylar or 28a-1 show	tor	MD			ltimo						10d. Inside City 1 Yes	,
th the or 28a	Funeral Director	10e. Street and Number		Du	TCIMO	10f. Zip Code	9		10g. Citize	on of What Cou	ntry?	
ath w	ral	603 S. Ann St.	Apt.			2123	1		USA			
er de:	nue	11. Marital Status	12. Was Decede Armed Force	es?	l.S. 13.	Was Decedent of If Yes, specify Ci	of Hispanic Origin? (S uban, Mexican, Puer	Specify Yes or Note 1	10- 14	Race - Amend Black, White,		
is 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Meanlard Hygiens. If mealth and Meanlar Hygiens are the first that an expectation of the first of th	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🔀 Divorced	1 ☐ Yes 2 If Yes, Give Year or Date	_		1□Yes 2☐	lo Specify:		S	pecify:Whi		
72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dece	dent's Usual Occ	cupation	nkina	16b. Kind	of Business/In	dustry	
Z I Z I 5-UU56 d within 72 hours aff giene. er than "natural; or the Medical Exami	ldmo	Elementary/Secondary (0-12)	College (1-4	or 5+)	1		ne during most of wo ired)	, and				
Lal ylallu 2 12. 2 should be filed within and Mental Hygiene. Is marked other than aumatic evant, tre M.	a)	17. Father's Name (First, Middle, Last)		Dome	scie	18. Mother's Na	me (First, Midd		rate Ho	me	
Ind yid IO	To B	James Peddicord	Ē				Irene	Johnso	n	,		
2 sho and ? ls ma		19a. Informant's Name/Relationship (19b. Mailir	ng Address (Stre	et and Number or R	ural Route Num	ber, City or T	own, State, Zip	Code)	
Deficiency in the pages 1 and 2 Department of Health mportant: If item 27 I any injury or other trance.		Emily Natividad	daug	hter)	603	S. Ann	St. Ap			CO.MD 21231		
3 00 L		1 Burial 2 Tremation 3		1 01		sition (Name of natory or other p		Date		tion - City or To		
Daltillole, permit. Pages 1 ar Department of Hea Important: If itam any injury or othe		' 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lices		Ba	yview	Cremat	tory 5-2	26-05	Duno	lalk,MI)	
permit. DepartmImports any inju		> Melester	Maria	1	2.	007 Eas	^{dress of Facility} We stern Av	siey C	havis	Jr. E	PH 2.1	
		23a. Part1. Enter the disease or comshock, or heart failure. List only	plications that cau one cause on eac	ed the deat	h. Do not ent	er the mode of d	ying, such as cardia	or respiratory	arrest,	D 212	Approximate Interval Between	een
Physician		Immediate Cause (Final disease or condition	a Bilia	_	eps s						Onset and De	
/Medical Examiner		resulting in death)	Due to (or	as a conseq	uence of):						1 0.04	3
	er	Sequentially list conditions, if any, leading to immediate b. Billian MSS Due to (or as a consequence of):							3 m			ths
cuted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									3 40	305
cate be executed physician and the burial-transit		resulting in death) Last	Due to (or	as a conseq	uence of):							
icate be exphysician sthe buria	Physician/Medical		d									
death certific e attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	me of pregna	incy				220	d. Date of delive	54	
the death cert the attendin ched for use	slcia	in the past 12 months? 1 ☐ Yes 2 No	1□Live birth 4□Pregnani	t at time of d		Ectopic pregnan Other (specify)			200		Day Ye	ar
that the de red by the a detached t	Phys	9 Li Unknown 🔻	9∐ Unknowr									
gne g	by	Part II. Other significant conditions of	ontributing to death	h but not resi	ulting in the ur	iderlying cause g	pven in Part I.			contribute to th		
sician: The law requir certificate has been si irector, page 2 should l	etec	CATRICAL TUDE.	inction)					-	Yes 2 24	40 3 Proba	ably 4 ⊡Uni	known
The law ate has b page 2 st	ompleted							24a. Was		24b. Were autop prior to con death?	ssy findings av apletion of cau	ailable ise of
sician: Th certificate rector, pag	e C	25. Was case referred to medical					26. Place of Dea	1 ☐ Yes	2 No		2X No	
Physician: r this certific ral director,	ToB	examiner? 1 🗆 Yes 2 📉 No	Hospital: 1 Inpa	atient 2	ER/Outpatient	3 DOA 0	4b	ome 5 ☐ Res		Other (Specify)	
		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of II (Month, I	njury Day Year)	28b. Time of Injury	28c. Inju		28d. Describe				
or Attanding after death. Diractor: After d in by the fune.	catl	2 Accident investigation 3 Suicide 6 Could not be				M 1[JYes 2□No					
or Attancater death Diractor:	ertification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (City or To	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Hospi 4 hou Funer ely fill	edical C	29a. Certifier (Check only one) (Check only one)	ysician: To the be niner: On the basis and manner	s of examinal	wledge, death tion and/or inv	occurred at the estigation, in my	time, date and place opinion, death occu	, and due to the	cause(s) and date and pla	d manner as sta	ated. the cause(s)	
To the within 2 To the complet	Me	29b. Signature and title of certifier	3.75			29c. Licer	nse number		29d. Date si	igned (Month, E	Day, Year)	
		1 Kane		H.D.		25	5-000		May	21,2	008	
1		30. Name and address of person who	completed cause o	f death (Item	23a) (Type, F	Print)	meet B	-	د الم	ula 4	21205	००४
Stat Registra	te ar	31. Date filed (Month. Day, Year)		strar's Signat	ture	sele .				, = -		

	. FOI	artment of Health and Menta rtificate of Death	Il Hygiene	18037
	1. Decedent's Name (First, Middle, Last)	2. Dat Mo	e of Death nth Day Year	3. Time of Death
Physician /Medical	Marian Louise Gundy	May	25, 2005	4:00 A M
Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dea	ith
	Suburban Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Bethesda If Under 1 Year If Under 24 Hrs. 8, Dat	Montgome	
Funeral Director	473-01-8976 1 M 2K) F 89 Yrs.	Months Days Hours Min. (Mo	onth, Day, Year) C	thplace (State or Foreign ountry) nesota
land	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
Marylan f show lied at	Maryland Montgomery Bethesda			1 ☐ Yes 2Ã No
with the Mar to 28e-f s be notified	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	ountry?
th wit	7916 Sleaford Place	20814	United Sta	ates
er dea	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, 1 □ Yes 2 ☎ No <i>Specify:</i>	s or No- etc.) 14. Race - Am Black, Whi Specify:	
15-00, 72 hours "netural" idical Ex	15 Decedent's Education 16a Dece	dent's Usual Occupation	16b. Kind of Business	
Maryland 21215-0036 Id 2 should be filed within 72 hours att th and Mental Hyglene. 27 Is marked other than "netural", or traumatic event, the Medical Exam. To Be Completed by F	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of working DO NOT use retired) al Draftsman	National of Health	•
be filed ital Hyg and other event,	17. Father's Name (First, Middle, Last)	18. Mother's Name (First,	Middle, Maiden Sumame)	
should be and Ments a marked umatic e	Ingwald Alfred Swan	Amy Florence	e Erickson	
re, Marylances and 2 should be for Health and Mental Health and Mental Health and traumatic every other traumatic every To Be	1.11	ng Address (Street and Number or Rural Route		Zip Code)
her her		Inverness Ridge Road		20854
MOre		matory or other place) May 31,	20c. Location - City of	
Baltimore, oermit. Pages 1 ar Department of Hea Mportant: If item my injury or other once.		emorial Park 2005	Rockville,	
Baltimore permit. Pages 1 Department of P Important: If its any injury or ot page.	21. Signature of Funeral Service Licenspe William a Fune flusy M01173	2. Name and Address of Facility Obert A. Pumphrey Funeral 557 Wisconsin Avenue, Bet	Home, Bethesda-Cho hesda, Maryland	evy Chase, Inc 20814
760, Attachment the be executed he burial-transit to burial-transit total Examiner	23a. Part1. Enter the disease, or complications that aused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, flag, backing to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			Approximate Interval Between Onset and Death days
Box 687 eath certificate attending phys for use as the]Ectopic pregnancy] Other (specify)	23d. Date of de Month	livery Day Year
rds, P.O.	Part II. Other significant conditions contributing to death but not resulting in the u Diabetes Mellitus, Hypertension,	nderlying cause given in Part I. 23	e. Did tobacco use contribute t 1 ☐ Yes 2 ሺ No 3 ☐ P	
Division of Vital Records, or Attending Physician: The law requires that after death. Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by	Reflux Esophagitis, Hypothyroidism		a. Was an autopsy prior to death? Yes 2\(\Delta \) No 1 \(\Delta \) Yes	utopsy findings available completion of cause of
f Vita ysician: is certific director,	25. Was case referred to medical examiner?	26. Place of Death (Chec		
of V Physic this or al dire	1 ☐ Yes 2X No Hospital: 1 X Inpatient 2 ☐ ER/Outpatient	the state of the s		ecify)
sion of tending Ph tor: After th the funeral	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year)	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	scribe how injury occurred	
Division of or Attending Parties death. Director: After tin by the funeration:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office 28f. Loc	cation (Street and Number or R y or Town, State)	ural Route Number,
Divisit To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier (Check only one) 1X Certifying Physicien: To the best of my knowledge, deat 2 Medicel Exeminer: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, and due vestigation, in my opinion, death occurred at th	to the cause(s) and manner a e time, date and place, and du	s stated. e to the cause(s)
To the Mithin Complex Complex Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mon	th, Day, Year)
	1 Mas Shih 190	D20516	May 27, 2	005
.6	30. Name and address of person who completed cause of death (Item 23a) (Type, Joel Schulman, M.D. 6000 Executive	Print) Blvd. #300 Rockvill	a Maryland 2	0852
State Registrar	31. Date filed (Month, Day, Year) MAY 3 1 2005 MAY 3 1 2005	W	c, maryranu Z	0032

			For Stete Registrar		ryland / Depa <i>Ce</i>	artment of I		lental Hygie	2000	18038
	nysicia		1. Decedent's Name (First, Middle, Lass Dorothy M. Gross					2. Date of Death	Day 70492	3. Time of Death
The state of the s	Medic xamine		4a. Facility Name (If not institution, give		opital	4b. City, Town,	or Location of Death	They (4c County of Deat	7 (
	neral ector		5. Social Security Number 6. Se	X 7. Age	In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Ye Mar 30, 1	9. Birt Co 1929 Nev	hplace (State or Foreigr untry) W York
ryland	3		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
death with the Maryland	otifie	Director	MD Anne Aru	ndel	Glen	Burnie	· · · · · · · · · · · · · · · · · · ·	100	Chi	1 Yes 2 No
th with	181 26		102 Crain Highw	ay #879			1061	Tog.	Citizen of What Co USA	untry?
P P P	other traumatic evant, the Medical Examiner must be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	0	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: wh	e, etc.
5-00	ical E		15. Decedent's Edu (Specify only highest grad	Year or Dates:	16a. Dece	dent's Usual Occu	pation	. 16b	o. Kind of Business/	
2121 d withir giene.	t, the Med	Completed	Elementary/Secondary (0-12) unk u	College (1-4or 5+ nk	F)	ter help	during most of work	Re	ttle Tave	
land if the fill the	C evan	To Be	17. Father's Name (First, Middle, Last)			unk	18. Mother's Name	e (First, Middle, Maid	den Sumame)	
Maryland 2. Maryland 2. In and Mental Hygis 77 Is marked other:	aumati	ř	19a. Informant's Name/Relationship (7)				and Number or Rura	al Route Number, Ci	ity or Town, State, Z	ip Code)
ore, M	ther tr		Peggy Cochran/da	ughter			ostead, MD		. Location - City or	r 61-1-
<u> </u>	njury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral 3 rvice Licens	1	20b. Place of Dispo cemetery, crer			200	. Location - Gity of	TOWN, State
Balti permit. Departr	any i		Ronald S.	Jade, Dire	ctor	Name and Addre State Ana Baltimore	tomy Boar MD 212	d 655 W.	Baltimore	Street
Physic			23a. Pant : Enter the disease, or compl shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ications that caused to cause on each line	the death. Do not ent	er the mode of dyin	ng, such as cardiac o	or respiratory arrest,		Approximate Interval Between Onset and Death
/Med Exam	iner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Conge	consequence of):	east E	pilure			
68760, ificate be executed g physician and		edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):					
Box eath cert	nse s	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	! ☐ Fetal death 3 ☐	Ectopic pregnancy	у		23d. Date of deliver Month	very Day Year
ords, Paquires that			Part II. Other significent conditions con	ntributing to death but	not resulting in the ur	nderlying cause giv	ven in Part I.		co use contribute to	
Division of Vital Records, P.O. for Attanding Physician: The law requires that the daffer death. Director: After this certificate has been signed by the	page 2	Completed						24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
Vital F sician: Th	rector	e a	25. Was case referred to medical examiner?	lospital:		Oth	26. Place of Death			
n of ing Phys	uneral d	on: lo	1 Yes 2 No 27. Manne of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	28b. Time of	28c. Injur	y at 2	ne 5 Residence 28d. Describe how in		fy)
Divisio or Attandi after death	in by the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injurbuilding, etc.	y - At home, farm, stre (Specify)		Yes 2 No	28f. Location (Street City or Town, Sta		al Route Number,
Division of To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th	oletely filled	Medical Ce	29a. Certifier 1 Certifying Physical Examinations 2 Medical Examinations	sician: To the best of her. On the basis of e and manner state	my knowledge, death examination and/or invest.	occurred at the tirestigation, in my o	me, date and place, a pinion, death occurre	and due to the cause ed at the time, date a	o(s) and manner as sand place, and due t	stated. o the cause(s)
To th within To th	comp	Me	29b. Signature and title of certifier Description Des	e Will	四四四	29c. Licens	e number / 1365		Date signed (Month,	
		_	30. Name and address of person who co				Drive, G	den Bur	nie, MD.	21061
Po	State	8	31. Date filed (Month, Day, Year)	82 Registrar	's Signature	21				

			1 - For State Registrar	State o	f Maryla	nd / Depa			lealth a	and M	lental F	lygie Reg.	ZUU	5	180	139
	Physici	an	Decedent's Name (First, Middle, Last	•							2. Date of Month	Death	Day	Year	3. Time o	of Death
	/Medic	al	Claude Grimes J		A 1						May	17	2005	20	7:00) AM ^M
	Examin	er	4a. Fecility Name (If not institution, give 2643 Miles Aven		nber)			Town, or L ti mo	Location o	of Death			4c. County of	Deeth		
	Francis	-	5. Social Security Number 6. Se		7. Age (In vrs	. last birthday)		r 1 Year		24 Hrs.	8. Date of	Birth		9 Birthr	olece (Stete	or Foreign
г	Funeral Director			ØM 2□F	46	Yrs.	Months	Days	Hours	Min.	(Month,	Dey, Ye	99 <i>r</i>)	Cour	yland	o o. o.g.,
	P		Usual Residence of Decedent								o dile	17,	1750			
	arylar show	-	10a. State 10b. County		10c. C	ity, Town or Lo								1	Od. Inside C	•
	Me M	Director	MD			Baltin						1				2 No
	with t	2	10e. Street and Number	_			10t. Zi	Code	1011			10g.	Citizen of Wh		ntry?	
	leath	era	2643 Miles Avenue	12. Was Dece	dent Ever in I	U.S. 13.	Was Dece		1211 ispanic Orio	gin? (Spe	ecity Yes or	No-		SA - Americ	an Indian,	
က	or Her	Fun	1 ☐ Never Married 2 Married	Armed Fo 1 ☐ Yes	rces? 2 🕅 No	1				Puerto	ecify Yes or Rican, etc.)			White,	etc.	
Ö	ral', o	Completed by Funeral	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or Da	e ates:		1 □ Yes	2X No	Specify:				Specify:	Ъ1	.ack	
2-0	72 h natu	etec	15. Decedent's Edu (Specify only highest grad	ication le completed)		16a. Deced	kind of w	rk done o	durina most	t of worki	ng	16	. Kind of Busi	iness/In	dustry	unk
12	within ne. than	mp	Elementary/Secondary (0-12)	College (1	-4or 5+)		DO NOT L	se retired)							
D	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ant, tha Mudical Examinat must be notified at	ပ္ပိ	17. Father's Name (First, Middle, Last)			mc	ver		18. Mothe	r's Name	(First, Mide	die. Mai	den Sumame)		
Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If it item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Mudical Examinating must be notified at	To Be	Claude J. Gri	nes Sr							ia A.					
ary	2 shows and he is ma		19a. Informant's Name/Relationship (7)	γρε, Print)		19b. Mailir	ng Addres	S (Street a	and Numbe	r or Rura	l Route Nui	nber, C	ity or Town, Si	tate, Zip	Code)	
≥ ~	and ealth m 27		Gisele Grimes/sp	ouse					renue		imore	, M	2121	.1		
016	ges 1 f of H ff ite or oti		20a. Method of Disposition 1 Burial 2 Cremation 3 F	Removal from :	- 1	Place of Dispo cemetery, cren	sition (Na natory or	me of other plac	e)		ate	200	. Location - C	ity or To	wn, State	
Ë	t. Pa ntmen rtant: njury	1	*4 ∑Donation 5 ☐ Other (Specify)		7				1							
Ba	permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Licens Ronald S.	Wade, I	recto		Namea tate iltim	Anat	omy B	oard 2120		√. B	altimo	re S	treet	
Н	Sal		23a. Pen Enter the disease, or compi shock, or heart failure. List only o	lications that co	aused the dea	th. Do not ent	er the mod	de of dyin	g, such as	cardiac o	r respirator	arrest,			Approxima Interval Be	
	Physician	k In	Immediate Cause (Final disease or condition	- C	AGTRI	C. C	AN	CFG	2						Onset and	
	/Medical Examiner		resulting in death)	Due to (or as a conse		, ,,,	027								
n	- Sammer	_	Sequentially list conditions,	b												
	ped isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):										
<u>,</u>	execu n and ial-tra	Examiner		Due to (or as a conse	quence of):										
8760,	death certificate be executed e attending physicien and id for use as the burial-transit	dicail		d												
9	ntifica ng ph s as th		IF FEMALE:													
Вох	death certifica attending pt d for use as t	lan/l	23b. Was decedent pregnant in the past 12 months?		irth 2 ☐ Fet	al death 3	Ectopic p						23d. Date			Year
<u>.</u>	the de	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregn. 9☐Unkno	ant at time of	death 5∟	Other (sp	pecify)				-	, worth		ou,	, coai
۵.	res that t igned by be deta		Part II. Other significant conditions co.	ntributing to de	ath but not re	sulting in the ur	nderlying o	ause give	en in Part I.		23e. Di	d tobac	co use contrib	ute to th	e cause of	death?
rds,	The law requires that the te has been signed by the rage 2 should be detache	ed by									1 (] Yes	2 □ No 3	☐ Prob	ably 4 🗆	Unknown
Vital Record	e law re has bee	Completed									24a. W		24b. We	re auto	psy findings	available
Ĕ		Com										topsy rformed 2 D	?/ dea	ath?	πpletion of α 2□ No	ause or
/ita	sician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?							of Death	(Check on					
<u></u>	Physi this c	2	TLI TES ZLENO			ER/Outpatien	-		4 🗀 (40)				6 □Other		")	
Division of	ding After funer	tion	27. Manner of Death 1 D Natural 5 Pending 2 Accident investigation	28a. Date of	h, Day Year)	28b. Time of Injury	м	28c. Injury Work	at ≀? /es 2 □ N		28d. Describ	e how i	njury occurred			
ls.	or Attendate death Director: in by the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place	of Injury - At h	nome, farm, stre				_	8f. Location	(Stree	and Number	or Rura	Route Nun	nber,
á	s after al Dire	Certification:	4 Homicide	buildir	ng, etc. (Spec	rfy)					City or T					
	To the Hospital or Attuwithin 24 hours after de To the Funeral Direct completely filled in by the	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami													5)
	To the within to the comp	×	29b. Signature and title of certifier				29	. License	number	2		29d.	Date signed (Month, I	Day, Year)	
				e MC)			D	1661	9		1	May 2	4, 0	2005	•
		18	30. Name and a devise of person who co	mpleted cause	e of death (Ite	m 23a) (Type.	Print)	OUA	RE .	DR.	BAC	TIL	IDRE,	Me	0. 21.	236
	Sta	te	31. Date filed (Month, Day, Year) MAY 3 1 200	_ 32. Re	egistrar's Sign	ature	49 -			-						
14.	Registr	_	MAY 3 T 500	3 Sec	wer h	F GOOD	Me de									

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** May 7, Louis Gibbs 2005 5:15 PM /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Long Green Nursing Home Baltimore If Under 24 Hrs. Hours | Min. Birthplace (State or Foreign Country)
 unk If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 M 2□ F Yrs. 718-09-7945 86 Apr 27, 1919 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location MD 1√2 Yes 2 □ No Baltimore Directo r than "natural", or items 23a or 28a-f the Medical Examiner must be notified 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 210 N. Washington Street Funerai 21213 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. filed within 72 hours efter 1 ☐ Yes 2 No 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry unk unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk unk 8 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 115 Melrose Avenue Baltimore, MD 21212 Long Green Nursing Home 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Injury or 4 □ Donation 5 NOther (Specify) in state 21. Signature of Funeral Service Licensee Rohald S. Wade, 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examine buriel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Division of Vital Records, P.O. Box 68760, Physician/Medicai USB BS ettending (23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Upknown 1 ☐ Yes 2 ☐ No bengis be det ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed certificate has t irector, page 2 s 1 Yes 2 TN 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No 4 Narsing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury et Work? Date of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred

Attanding Physician: The law requires that the deeth certificate be executed After this certification within 24 hours efter death.

To the Funeral Director: Af
completely filled in by the fu ò To the Hospital

State

edicai

1 Matural

2 Accident

3 Suicide

29a. Certifier

4 - Homicide

30. Name and addre

31 Date filed (Month

29b. Signature and title of certified

5 Pending

O1

s of person

Day, Year,

3 1 2005

investigation

6 Could not be determined

DHMH 16 Ray 6/95

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

who completed cause of deeth (Item 23a) (Type, Print)

32. Registrar's Signature

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

			1- State of Maryland		artment of H			giene Reg. No.	05	18041
	Physicia		1. Decedent's Name (First, Middle, Last) Samuel Heft				2. Date of Dei Month MAY 28	Day	Year	3. Time of Death 12:22 P M
	/Medic Examin	er	4a. Facility Name (If not institution, give street and number) I - 95 SB @ MM 109		4b. City, Town, or ELKTON				unty of Death	
	Funeral Director			last birthday) 50 Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bird (Month, Da April	13, 1	9. Birthp Cour 945	place (State or Foreign ntry) MA
	Maryland -f show	ō	Usual Residence of Decedent 10a. State NJ Somerset 10c. City	y, Town or Lo	ocation	Bas	king Ridge	e	1	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	3e or 28a	I Director	10e. Street and Number 97 Juniper Way		10f. Zip Code 07920			10g. Citizen USA	of What Cour	ntry?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural; or items 23s or 28s-f show other treumatic event. Its Medical Examinar must be nullified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi tf Yes, specify Cuba 1 ☐ Yes 2 XNo	spanic Origin n, Mexican, F Specify:	? (Specify Yes or No Puerto Rican, etc.)		Race - Americ Black, White, ecify:	
21215-0036	in 72 hours n "natural" dedical Ex	Completed b	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	turing most of	f working	16b. Kind	of Business/In	dustry
1d 212	12 should be filed within 'n and Mental Hygiene. 7 Is marked other then "treumatic event, the Mea	Be Com	Elementary/Secondary (0-12) 12 College (1-4or 5+) 5+ 17. Father's Name (First, Middle, Last)		Vice Pres	18. Mother's	Name (First, Middle,	Maiden Sur	rmaceut	tial
Maryland	hould by d Menta marked matic e	ToE	Harold Heft 19a. Informant's Name/Relationship (Type, Print)	19b. Maili	na Address (Street a		ne Baskwi		own, State, Ziı	o Code)
	and 2 s ealth an n 27 is r	- Parliament	Barbara Heft	97	Juniper W		sking Rido	ge NJ	07920	
lore	Pages 1 and the part: If Item		1 Burial 2 Cremation 3 Removal from State	emetery, crei	osition (Name of matory or other plac ael cem		Date 1/2005		ion - City or To dbridge	
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 Is any injury or other tree				2. Name and Addres	s of Facility L. Ste	vens Funer Avenue, E	al Ho	me, Ind	C.
	Pnysician		23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	-	ter the mode of dyin	g, such as ca		rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of the control of the c		10101	1 10,0000	1-21.11	112		
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the content of							
.O. Box 68	ath certific attending p for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnat 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	Ideath 3	⊒Ectopic pregnancy ⊒ Other (s <i>pecify)</i>			23d	l. Date of delive Month	ery Day Year
Ο.	w requires that the deben signed by the should be detached	d by Ph	Part II. Dther significant conditions contributing to death but not rest	ulting in the u	underlying cause giv	en in Part I.	23e. Did t	5_/	/	the cause of death?
Recol	e tav has je 2	Complete					24a. Was auto perio 1 Pes	an 2 psy prmed? 2 \(\subseteq No	prior to co death?	opsy findings available ompletion of cause of
Vita	sicien: certific rector,	Be	25. Was case referred to medical examiner? Hospital: Hospital:	FB (0	oth Oth	05	f Death (Check only o		Othor (Casa)	y) SCENE
Division of Vital Records,	fune fune	Certification; To	1 Yes 2 No	28b. Time of Injury	of 28c. Injun World		28d. Describe	how injury on ECU UNUS	Courred PID PID PID CO	IL AND OVERTURE WITH CAST All Route Number,
Ō	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical Cert	29a. Certifier 1 Certifying Physician: To the best of my kno (Check only 20Medical Examiner: On the basis of examina	wledge, dear	th occurred at the tin	ne, date and	place, and due to the	Cause(s) and	d manner as s	stated.
	To the H within 24 To the F complete	Medi	29b. Signature and title of certifier MOUNTE Med Joule M	0	29c. Licens OCN	e number		29d. Date s	igned (Month. 29, 200	Day, Year)
_	10		30. Name and address of person who completed cause of death (Item MXNYD MT) . KDREW		Print) 111 Per	n Stre	eet Balti	more,	Maryla	nd 21201
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signal	ture	sele					

		•	1 - For State Registrar	State of Maryland		rtment of He			giene 0 0 5	18042
	Physici /Medic		Decedent's Name (First, Middle, Last, Valdez					2. Date of Deal Month		3. Time of Death 9:45am м
	Examin		4a. Facility Name (If not institution, give Holy Cross Hospi			4b. City, Town, or L Silver Sp	pring		4c. County of D	Montgomery
	Funeral Director			x 7. Age (In yrs. las 46	t birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) 06/04	, Year)	Birthplace (State or Foreign Country)
	Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County Di	st. of Columbia	Town or Loc	cation	Washing	gton		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the 3a or 28e	i Director	10e. Street and Number 1835 D. Str	eet NE #3		10f. Zip Code	20002	1	0g. Citizen of What	Country?
020	1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. Raz I is markled other than "netural", or Items 23a or 28e-f show ther traumatic event, the Medical Exagination and the religion.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	lf lf	Vas Decedent of Hisp Yes, specify Cuban, □ Yes XXNo	panic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, V	American Indian, Vhite, etc. Black
2.513.3	d within 72 ho giene. er than "netur . It a medicil	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12) 12		(Give k	ent's Usual Occupati kind of work done du O NOT use retired) COOK	ion ring mast of work	ing	16b. Kind of Busine	ess/Industry
la la	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Marken	To Be C	17. Father's Name (First, Middle, Last) Charlie Hall			1		e (First, Middle, i la Butle:	Maiden Surname)	
Mai	nd 2 sho Ith and I 27 is ma r trauma		19a. Informant's Name/Relationship (T) Kimberlyn Parramo:			g Address (Street and 40 Wax Be.			r, City or Town, State	
ָנֻ פֿ	permit. Pages 1 and 2 should be purtment of Health and Men Important: If item 27 is marke any injury or other traumatic.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 ★ 4 □ Donation 5 □ Other (Specify)	Pemoval from State	e of Dispos	ition (Name of atory or other place) Cemetery	-1	Date	20c. Location - City Jacksonv	or Town, State
ספוני	permit. Departm Importa any inju		21. Signatureret Funeral Service Licens	9	22.	Name and Address Charles L. 1501 Fast	of Facility Stevens I	uneral Ho	me Inc.	,
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the death. ne cause on each line. Aids a Due to (or as a consequer		r the mode of dying,	such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
	Examiner	Į.	Sequentially list conditions,	b. CVA Due to (or as a consequent						
	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Aids Ene	ohalya	athy				
,,,,	ficate be executed physician and is the burial transit	dical E	l	Pulmonary		olis				
.C. 504 0	ne death certi the attending thed for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnanc 1 Live birth 2 Fetal de 4 Pregnant at time of deal	eath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
L (cn)	quires that the signed by all be detacted	by	Part II. Other significant conditions co	ntributing to death but not resulti	ng in the un	derlying cause given	in Part I.			e to the cause of death? Probably 4 Unknown
מיסה ומ	sician: The law requir s certificate has been si lirector, page 2 should	Completed						24a. Was a autops perform	ned? prior deatl	e autopsy findings available to completion of cause of n? Yes 2 □ No
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	nysiciar iis certif director	To Be	25. Was case referred to medical examiner? 1 Tes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ EF	VOutpatient	Other	26. Place of Deat 4 Nursing Ho		ence 6 □Other (S	Specify)
	Attending Physician: The sr death. ector: Alter this certificate his by the funeral director, page		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injury a Work? M 1 \(\text{Ye}	at es 2 🗆 No	28d. Describe ho	ow injury occurred	
	tel or Att rs after de el Direct	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom- building, etc. (Specify)				City or Town	n, State)	r Rural Route Number,
	To the Hospitel or Attendin within 24 hours after death. To the Funeral Director: At completely filled in by the fur	Medical	(Check only 2 Medical Exami	sician: To the best of my knowle iner: On the basis of examination and manner stated.	adge, death n and/or inv	estigation, in my opir	nion, death occur	red at the time, d	ate and place, and	due to the cause(s)
	To To no	2	29b. Signature and title of certifier	15 ME)	29c. License r D41624			9d. Date signed (M May 3,200	
į	0		Patrick Murphy				Spring	MD 2091	0	
¢,	Registr		31. Date filed (Month, Day, Year) MAY 3 1 2005	32. Registrar's Signatur	Sport	E .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Clara L. Hawkins 05/20/05 4:45pm 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Mariner Health of Glen Burnie Glen Burnie Anne Arundel 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day. Birthplace (State or Foreign Country) 214-24-7174 Days Hours Min 1 □ M 2875F 86 Yrs. 03/31/1919 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Glen Burnie 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 1011 Big Bear Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: white 3 XWidowed 4 ☐ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Convience Store Store Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Reverdy D. Hawkins Hattie Pardoe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 6500 CRestwood Road Baltimore Maryland 21239 Raymond D. Hawkins 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XXurial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery 05/25/2005 Glen Burnie MD 4 □ Donation 5 □ Other (Specify) ature of Funeral Service Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 victor P. Doda, Jr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cirose 0 Due to (or as a conseque ce of):

/Medical Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, s after death, if Director: Al filled in by within 24 hours

Physician

/Medical

Examiner

Funeral

Director

r then "neturel", or items 23s or 28e-f show the Medical Examiner must be notified at

Director

Funeral

ģ

Be Completed

္ပ

Physiclan/Medical Examiner

Be Completed by

2

Medical Certification:

31. Date filed (Month, Day, Year)

MAY 3 1 2005

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

I Hygiene.

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Importent: If item 27 is marked other any injury or other treumatic event,

Physician

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Lines Unuerlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o	uence of):		~~! u _c	li viery mon
IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 Yes 2 No	23c. If yes, outcome of pregnative birth 2 Feta 4 Pregnant at time of d	I death 3 Ectopic p			23d. Date of delivery Month Day Year
Part II. Other significent conditions of	contributing to death but not res		cause given in Part I.		o use contribute to the cause of death?
Chranic	& Tries	5-6r	Motion	24a. Was an autopsy performed 1 Yes 2	
25. Was case referred to medical			26. Place of De	eath (Check only one)	
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 I	ER/Outpatient 3 D	OA Other: 4 Nursing	Home 5 Residence	6 ☐Other (Specify)
27. Manner eath 1 latural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred
3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, facto y)	ry, office	28f. Location (Street City or Town, Str	and Number or Rural Route Number, ate)
29a. Certifier 1 Certifying Pr (Check only one) 2 Medical Exar	nysicien: To the best of my kno miner: On the basis of examina and manner stated.	owledge, death occurred ation and/or investigation	d at the time, date and place n, in my opinion, death occ	ce, and due to the cause curred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and little of certifier	Omb	29	Dc. License number	29d. [Date signed (Month, Day, Year)

BATTimas, MD, 21226

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rnnington

32 Registrar's Signature

		-	For State Registrar	Otato of Maryta	Ce	rtificate of E	Death		ig. No.	J	10044
Phy	sicia		1. Decedent's Name (First, Middle, Las					2. Date of Death	Day	Yeer	3. Time of Death
	rsicia ledic		Della	Harris				May 29,			12:20 pм
Exa	amin	er	4a. Facility Name (If not institution, give North Daks Reti:			4b. City, Town, or Pikesvi			4c. County	of Death timo:	
Firm	Town		5. Social Security Number 6. S		. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of BiRh		9. Birthp	ace (State or Foreign
Fune Direc				□M 2 X F 94	Yrs.	Months Days	Hours Min.	8. Date of Billy (Month Day, July 13,	1910	Mery	iland
pu »	e31e		Usual Residence of Decedent 10a, State 10b, County	100.0	ity, Town or Lo	nation				14	0d. Inside City Limits
laryla	20 31	2	MD 10b. County	100. 0	Baltir					'	1 X Yes 2 □ No
the N		Director	10e. Street and Number			10f. Zip Code		10	og. Citizen of W	hat Coun	trv?
with 3a or	90		2301 Pentland I	Or., Apt. 404		21234			U.S.A.		,-
death	8	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of His If Yes, specify Cuban	spanic Origin? (Spanic Origin?	ecify Yes or No-		- Americ	
DESILITIOFE, INTELYIGITION Z.I.Z.I.3-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show	a walling	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐XNo	Specify:	riodii, etc.)	Specify:		
72 ho	ESI	eted	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Occupa	tion uring most of work	ina	16b. Kind of Bu	siness/Inc	fustry
ithin a	Was	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done do DO NOT use retired) Secretary		9	Broke	⊃rane	Firm
iled w	를		17. Father's Name (First, Middle, Last)			-	18. Mother's Name	/First Middle A			
d be f	9 0	To Be	Scott	Deady			Sar			- ayhoi	ne
shoul od M	maria I	F .	19a. Informant's Name/Relationship (19b. Maili	ng Address (Street a	nd Number or Rura	al Route Number,			
and 2	er tra		Charles A. Harris	s-husband	2301	Pentland			Baltimo:	re, M	1D 21234
Ses 1	r of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cre-	osition (Name of matory or other place		Date 2	20c. Location - (City or To	wn, State
Dallimor	inry		4 □ Donation 5 □ Other (Specific) Hi		rvice Corp.			Towson, 1		
Denmit Depar Impor	any in		21. Signature of Funeral Service Licer	see Milliam G. Da		2. Name and Address 1050 York Ro				tome,	Inc.
			23a. Part1. Enter the disease, or com	olications that caused the dea						-12	Approximate
Physic	ian		shock, or heart failure. List only Immediate Cause (Final disease or condition	a. Chronic	oheto	101' NO 0.	1-0000	Diser	250		Onset and Death
/Medi	ical		resulting in death)	Due to (or as a conse	equence of):	ACHOC TO	ALMO, ICA	1 50300	7)		
Exami	ner		Sequentially list conditions, if any, leading to immediate	b							
pe :	sit	nine	if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):						
xecut	al-trar	Examine	that initiated events resulting in death) Last	cDue to (or as a conse	iquence of):						
certificate be executed ding physician and	e pru			ď							
diffical ng phy	as th	Medicai	IF FEMALE:								
8 5	or use		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr	tal death 3	Ectopic pregnancy			23d. Date Mon	of delive	ry Day Year
The law requires that the death cer ate has been signed by the attendir	ped fo	hysician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at time of 9□ Unknown	death 5[Other (specify)					,
that the	detac	Δ.	Part II. Other significant conditions of	ontributing to death but not re	sulting in the L	inderlying cause give	n in Part I.	23e. Did tob	acco use contri	bute to th	e cause of death?
necords, he law requires t e has been signe	eq pi	d by	Atrial fibrilla	ition, Dys	phagic	1		1 □ Ye	s 2 🗆 No	3 🗌 Prob	ably 4 Hiknown
o we red s	shou	ompieted	Congestive hea	,	-		rc	24a. Was ar		Vere autor	osy findings avaitable
The la	раде	mo	-		<u></u>			autops perform	ned? _ d	eath?	npletion of cause of 2□ No
VICAL ilcian: T certificat	ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of Deatl	(Check only on	9)		
Physic This c	al dire	၉	1 Yes 2		ER/Outpatie	The second second	4 Enduising No	me 5 Reside)
Jing F	funera	ertification:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	at ? ′es 2 □ No	28d. Describe ho	w injury occurre	9 a	
l or Attending after death. Director: After	y the	ficat	2 Accident Investigation 3 Suicide 6 Could not b		home, farm, st		03 2 0.10	28f. Location (Str	reet and Numbe	or Or Rura	I Route Number,
al or /	d i i	Serti	4 Homicide	building, etc. (Spec	cify)			City or Town	, State)		
DIVISION OF VITAL THE PROPRIES THE PAY TO THE HOUSE AT BOTH OF THE PAY WITHIN 24 HOURS After this certificate has To the Funeral Director: After this certificate has	etely fille	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of my kr niner: On the basis of examir and manner stated.	nowledge, deat nation and/or in	th occurred at the time evestigation, in my op	e, date and place, inion, death occurr	and due to the ca	use(s) and mar ate and place, a	ner as st nd due to	ated. the cause(s)
To the within	compl	Me	29b. Signature and title of certifier	_		29c. License			d. Date signed		_
			> Thaven L	salret, M.	D.	1000	18676	1	may 3	1,20	05
5			30. Name and address of person who Karen L. Babita	completed cause of death (Ite	em 23a) (Type,		200 12	isters to	wn, MD	21	136
	Sta	te	31. Date filed (Month, Day, Year)	82. Registrar's Sign	nature	N. o					
Re	gistr	ar	MAY 3 1 200	Marion B	GOSA						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiệne 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0950PM 4a. Facility Name (If not institution, give street and number)

JOHNS HORKINS BAY VIEW MEST CAL LENTER

Raltimore /Medical 4c. County of Death Examiner N/A 8. Date of Birth (Month, Day, Year) Sept 30, 1 5. Social Security Number Il Under 1 Year Il Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 18755 1XM 2□ F Months Days Hours Min 83 Yrs. Sept Director Pennsylvania Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "natural", or items 23e or 28e-f show traumatic event, the Modical Examinat market or citified at 1 X Yes 2 □ No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1101 Steiger Way 21205 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No 1942 If Yes, Give Year or Dates: 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Laborer Steel Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Albert Hebden Bessie Burkey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 nent of Health a ant: If item 27 is Alice R. Hebden, Wife 1101 Steiger Way Baltimore, Maryland 21205 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State ō permit. Page Depertment of Important: If any injury or once. 05/31/05 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Metro Crematory Inc. 22. Name and Address of Facility Cremation Society Of Maryland Inc. 21. Signature of Funeral Service Licensee Thomas Gregor 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PULMONARY EMBOLI **Physician** /Medical Due to (or as a consequence of): Examiner METASTATIC SPINDLE CELL CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner physician and s the burial-transit certificate be execu Due to (or as a consequence of) Box 68760 as the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ cate has been sig , page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 Yes 25 No 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: in or λι.

cours efter death.

val Director: After ιι.

by the funeral director. 2 22 ER/Outpatient 1 Yes 200 No 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date ol Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours e To the Funeral L 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 D39221 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GWRGW CYFLEU O MID 17-57 FM. MLD) JOHNSHOPKINS BAY VIEW MEDICAL CENTER GURGIO CALEUD 31. Date liled (Month, Day, Year) MAY 3 1 2005 State Registrar

		1	State of Maryland Dep: 1- State of Maryland Dep:	artment of Health and M -05 tas rtificate of Death	lental Hygier	2°005 18046
	20		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia		Rosa Hollis		05-26-20	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			11517 Franklinville Road	Upper Falls If Under 1 Year If Under 24 Hrs.		Baltimore Ctata or Foreign
	Funeral		5. Social Security Number 417-28-4308 6. Sex 1 □ M 2 👀 7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye) 01-06-191	
	Director		417-28-4308 88 IIIs. Usual Residence of Decedent		101-00-191	
	yland		10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits 1 ☐ Yes 22 No
	e Mar	Director	Md Baltimore Upper Fa			
	or 28	Oire	10e. Street and Number	10f. Zip Code		Citizen of What Country?
	ath w	rai	11517 Franklinville Road 11 Marital Status 12. Was Decedent Ever in U.S. 13.	21156 Was Decedent of Hispanic Origin? (Sp		S.A. 14. Race - American Indian,
36	d within 72 hours after death with the Maryland piene. Ir than "neturel", or items 23a or 28e-f show It a Mydical Exant net must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Ammed Forces? 1 Yes 2 No 1f Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc. An Specify: White
21215-0036	"neturel	Completed b	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation a kind of work done during most of work DO NOT use retired)	ring 16b	b. Kind of Business/Industry
12	within iene. than "I	ф	Elementary/Secondary (0-12) College (1-4or 5+)	keeper	P	Accounting
<u>0</u>	를 수 를 ti	0	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	
lan	Q & 20 9	ToB	James Blaine Allen		Escolan	
Maryland	s 1 and 2 should be f Health and Mental I item 27 is marked or other traumatic eve			ing Address (Street and Number or Rur		
	2 # 7 E		not Plan of Diag	17 Franklinville	• • •	Falls, Md 21156 Location - City or Town, State
ore			1 Burial 2 Cremation 3 Removal from State	matory or other place)		
altimore,	tment tent:			Funeral Home 05/2		Ills Church, VA Funeral Directors
Bal	permit. Page Department of Importent: If any injury or once.				-	cown, Maryland 21133
	Pnysician /Medical Examiner	er	23a. Part 1. Enter the disease, or committations that caused the death. Do not enshook, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	ter the mode of dying, such as cardiac		Onset and Death
	be executed sician and burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
8760,	ate be ex hysician the buria		d			
Box 6	ath certific thending p	Physician/Medical	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
P.O.	that the de ned by the a detached f	ysic	1 Yes 2 12 No 9 Unknown			
	uires that n signed b id be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
Records,	sicien: The law requir. s certificate has been si lirector, page 2 should I	Completed			24a. Was an autopsy performe 1 ☐ Yes 2 Z	24b. Were autopsy findings available prior to completion of cause of death?
Vital	en: T	BeC	25. Was case referred to medical	26. Place of Dea	th (Check only one)	
>	Physicien: r this certific ral director,	To	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	ent 3 DOA Dther: 4 Nursing H		e 6 Other (Specify)
n of	ding Pt h. After th funeral		27. Manne Death 1 Latural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	28d. Describe how	injury occurred
Sio	Attending r death. sctor: After by the fune	catio	2 Accident investigation	M 1 Yes 2 No	28f Location (Street	et and Number or Rural Route Number,
Division	tel or Att rs after d el Direct ed in by	Certification:	4 Homicide determined 256 Place of Injuly Attionic, family, Substituting, etc. (Specify)		City or Town, S	State)
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) Check only one) Check only one) Check only one) Check only one) Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	irred at the time, date	and place, and due to the cause(s)
	To the vithing to the comp	Ň	29br. Signature any time or certifier White Manual	29c. License number	29d	Date signed (Month, Day, Year)
	10	<	30, Name and address of person who completed cause of death (kem 23a) (Type WAN P. LOWANDS, W. D.	- Print 21/2 BITA FAUSTON W	yang CA	ND 2/047
	St Regist	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	ande	0	
D	HMH 17 Rev 1/	4.00	MAY 3 1 2005 Seems of 19			

ORIGINAL

			For State Registrar	State of	Marylan		rtment of	Health and f Death	Mental H	ygie Reg	CUU2	18047
	Dhorisi		Decedent's Name (First, Middle, L	ast)	8011				2. Date of D		L∏ay Year	3. Time of Death
	Physici /Medic		ROLANDE						May	27	7 2005	630 A.M
	Examin	er	4a. Facility Name (If not institution, g Northwest Hospi				4b. City, Town, Randal	or Location of Dea Lstown	th <i>U</i>		4c. County of Deat Baltimor	
	Funeral Director				7. Age (In yrs 83	last birthday) Yrs.	If Under 1 Yea Months Day	r If Under 24 Hrs s Hours Min	8. Date of E (Month, I	Sirth Day, Ye	9. Birt 1921 Vi	hplace (State or Foreign nuntry) rginia
_	ਹ		Usual Residence of Decedent		40.00							
	show	ō	MD Baltin	nore		y, Town or Loo Rockdal						10d. Inside City Limits 1 ☐ Yes 2 No
	28a-1	Director	10e. Street and Number				10f. Zip Code			10g.	Citizen of What Co	
	h with 23e or		3421 Gaither Roa	ad			21244			Un	ited State	es Of America
36	should be filed within 72 hours after death with the Maryland and Mental Hygiene. marked other than "natural, or items 23e or 28e-f show matic avant, the Marifical Examinat must be rivilited at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Deced Armed Ford 1 1 2 Yes If Yes, Give Year or Da	ces? 2 □ No 9 WWI:	.S. 13. V	Vas Decedent of Yes, specify Cu	f Hispanic Origin? (Suban, Mexican, Puel o <i>Specify:</i>	Specify Yes or Note Rican, etc.)	10-	14. Race - Ame Black, White Specify: Wh:	e, etc.
5-0036	2 hou		15. Decedent's	Education		16a. Deced	ent's Usual Occ	upation	dies	16	o. Kind of Business/	Industry
2	ithin 7 ne. han "r	Completed	(Specify only highest of Elementary/Secondary (0-12)	College (1-	4or 5+)	lite. L	O NOT use reti				1 - 1	
2	Hygier Hygier thar th	Co	12 17. Father's Name (First, Middle, La	st)		Roller	of Rol	1ed Hot S			teel Indus	stry
an	Mental rkad o	To Be	Henry Hertsch						Doggett			
Ξ	12 h al 7 is		19a. Informant's Name/Relationship Mrs. Elaine Herr		pouse)						ity or Town, State, 2 cyland 21	
altimore,	- i a =		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	□ Removal from S	_	Place of Dispos	sition (Name of natory or other p.	lace)	Date	200	c. Location - City or	Town, State
Ĕ	. Pages tment of tant: If It iury or o		*4 ☐ Donation 5 ☐ Other (Spec	cify)	La					-	kesville,	
Ba	permit. Pages Department of I Important: If Its any injury or o once.		21. Signature of Funerel Service Lic	ensee								Directors,I yland 21133
ī,			23a. Part1. Enter the disease, or co shock, or heart failure. List on	ly one cause on ea	ich line.				c or respiratory	arrest		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	и			on 11	yout				0.001.0.10
	Examiner			Due to (d	or as a conseq	uence of):						
-	σ =	ner	Sequentially list conditions, if any, leading to immediate	Due to (c	or as a conseq	uence of):						
	be executed sician and burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c	or as a conseq	uence of):						
8760	cate be executed bhysician and the burial-transit	dicalE		d	,							
9	rtificate ng phys as the	0	IE ESMALE.	-							1	
O. Box	The law requires that the death certific te has been signed by the attending lage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nth 2 ∐ Fenta antattimerofd	Ideath 3□	Ectopic pregnar Other (specify)	icy			23d. Date of deli Month	ivery Day Year
т. Г	s that i ned by e deta	by Ph	Part II. Other significant conditions			4D .		given in Part I.	23e. Dio	tobac	co use contribute to	the cause of death?
rds	equires en signe ould be	ed b	phonois cope	roporci	vac.	injan	4, C	Morre	1 🗆] Yes	2 □ N6 3□Pr	obably 4 Unknown
Records,	The law requate has been page 2 shoul	Completed	atual fasile	itury,	Citu	may	Jan.	ery	24a. Wa aut per 1 ☐ Yes	opsy formed	prior to death?	topsy findings available completion of cause of
Vital		BeC	25. Was case referred to medical examiner?					26. Place of De	ath (Check only		7.10	20.110
o to	Physicia this cert al direct	မ	1 ☐ Yes 2 ᡚ No			ER/Outpatient	3 DOA	A CONTRACT			e 6 □Other (Spec	cify)
00	ding F h. After funera	tlon:	27. Manner of Death 1 1 Natural 5 □ Pending 2 □ Accident investigat		n, Day Year)	28b. Time of Injury		ork? □Yes 2□No	28d. Describe	9 now	injury occurred	
Division	or Attandi after death. Diractor: A in by the fu	Certification:	3 Suicide 6 Could not	be 28e. Place	of Injury - At ho g, etc. (Specif	ome, farm, stre	est, factory, office		28f. Location City or T	(Stree	it and Number or Ru	ral Route Number,
	itel or irs afte ral Dir led in	Cert									·	
	To the Hospitel or Attanding Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director,	edical			sis of examina						e(s) and manner as and place, and due	
	Tot Com	Σ	29b. Signature and title of certifier	an	MO		29c. Lice	nse number 54288		29d.	Nay 2	1 2005
	7		30 Name and address of person who was a summer of the summ	o completed cause	of death (Item	n 23a) (Type, I	Print) Mo	whive	r Hux	ni	tal Ce	15 200s
	Sta		31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa	ture	20					
S	Registr	ar	MAY 3 1 200	10 Healis	U St	19						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#5,205-c, per Fh, G045, //22/05 TT
State of Maryland? Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death Reg. No: 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Lancelot A. Hunter 20 2005 May 5:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Jacobo Place Towson Baltimore If Under 1 Year Months Days Birthplace (State or Foreign Country) If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 ☐ F Hours Min. 59 Yrs. Director Africa Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City. Town or Location 10a. State 10d. Inside City Limits item 27 is marked other than "netural", or items 23e or 28a-f show other treumatic event, the Marilea Examiner must be notified at tX Yes 2 □ No Directo Baltimore MD Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 Jacobo Place Africa Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ≦ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Engineer Graphic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental Arthur Hunter Iris Pratt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 Zia Hunter (wife) 558 S. Encina Ave. if item 20b. Place of Disposition (Name of cornetery crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State ō Lona Linda permit. Page Department of importent: if eny injury or once. 6-4-05 ^ 4 □ Donation 5 □ Other (Specify) LOS 21. Signature of Funeral Service 22. Name and Address of FacilityWesley Chavis Jr. FH 2007 Eastern Ave. Balto. MD 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Pnysician colon 4car /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The taw requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ò Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, Known 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown hone 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 X No certificate 1 Yes Division of Vital the Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo Certification: To After the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Thomicide within 24 hours a To the Funerel D 29a. Certifier 1😿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Fun completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific D50736 Physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4000 Old Cour Rd # 203 Pikesville, MD 21208 MM Konkel 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

MAY 3 1 2005

			1 - State of Maryland / Department	rtment of Health and M tificate of Death		ene 0 0	5 18049
			Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	Physicia /Medic		Valerie Hrebicek		05	27 200	1 A A
}	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of	Death
			Manorcare Chevy Chase	Chevy Chase If Under 1 Year If Under 24 Hrs.			gomery
п	Funeral Director		5. Social Security Number 202-16-1854 6. Sex 1 M 203F 80 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, 12-27-	Year)	Birthplace (State or Foreign Country) Pennsylvania
		1	Usual Residence of Decedent		12 21	1724	Cennsylvania
	nyland how	. [10a. State 10b. County 10c. City, Town or Lo				10d. Inside City Limits
	e Ma 3a-f s	Director	MD Montgomery Chevy C	hase			1 X Yes 2 □ No
	or 20	Dire	10e. Street and Number	10f. Zip Code	10	g. Citizen of Wh	at Country?
	s 23a		8700 Jones Mill Rd. 11 Marital Status 12. Was Decedent Ever in U.S. 13. V	20815	anife Van as Na	USA 14 Page	American Indian.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be multified at ance.	by Funeral	1 TNever Married 2 Married 1 TYes 2 TNo	Vas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto ☐ Yes 2 No Specify:	Rican, etc.)		White, etc. White
21215-0036	2 hou	ted	15. Decedent's Education 16a. Decedent	ent's Usual Occupation	1	6b. Kind of Busin	ness/Industry
215	thin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of work DO NOT use retired)	ing		
7	ygien ygien yer th	Con	12 Admi	nistrator		Museur	n
Ind	be fill H	Be	17. Father's Name (First, Middle, Last) Vito Hrebicek	18. Mother's Name	e (First, Middle, M Orzechow		
Maryland	hould d Mer marke	은		g Address (Street and Number or Rum			ate Zin Code)
<u>8</u>	od 2 s Ith an 27 is : traus			5 N. Glebe Rd. Ar			
ē,	t Hea f Hea item other		20a. Method of Disposition 20b. Place of Dispo	sition (Name of Inatory or other place)	Date 2	0c. Location - Ci	ty or Town, State
Ë	Page: ient o nt: if ry or		1 Burial 2 ViCremation 3 Hemoval from State		28-2005	Beltsvil	le, MD
Baltimore,	permit. Departm Imports any inju		M00382 R	Name and Address of Facility app Funeral & Cre 33 Gist Ave Silve	mation S	ervices	0
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on early line.	or the mode of duing s as cardian	or receivatory arre	c†	Annrovimate
8760,	/Medical Examiner bhysician and bhysician and the prival-transit the prival-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfung Cause (Disease or Injury that initiated events resulting in death) Last Due to ras a consequence of): Due to ras a consequence of): d.	Cerebrovasa	ill S	esere	Syen
.O. Box 68	death certifi e attending ed for use as	Physician/Medi		Ectopic pregnancy Other (specify)		23d. Date of Month	1
<u>a</u>	es be	by	Part II. Other significant conditions contributing to death but not resulting in the un	iderlying cause given in Part I.	23e. Did tob		ute to the cause of death? Probably 4 □Unknown
I Records,	The ate h page	Completed			24a. Was an autopsy perform	prio dea	re autopsy findings available or to completion of cause of th? Yes 2 \sum No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Deat	h (Check only one)	
of	Ø ⊵. 🕇	10 10	1		me 5 Resider		
no	Jing After fune	llon	1 Natural 5 Pending (Month, Day Year) Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	200. Describe no	w injury occurred	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	ertification:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, structure building, etc. (Specify)		28f. Location (Str. City or Town,	eet and Number State)	or Rural Route Number,
	ours a	0	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place.	and due to the ca	use(s) and mann	er as stated
	To the Hospital within 24 hours a Yo the Funeral Completely filled	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or invane)				
	To th within To th compl	Me	29b. Signature and title of perfities	29c. License number	29	d. Date signed (i	Month Day, Year)
	0		· Come White	DAYIT	9 4	5627	103
	1)		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	/	1	
_/	U		James Foster 5530 Wisconsin Ave #92	Chevy Chase MD	20815		·
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 27, Year **Physician** 2005 10:46 AM Juanita Ruth Livingston Hansen /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Suburban Hospital Montgomery Bethesda If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan 16, 1914 **Funeral** Months 1 □ M 2 🖾 F 91 440-10-7179 Kansas Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "naturel", or items 23a or 28a-f ehow treumetic event, the Madical Examinar must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20816 5103 Westridge Road United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: Specify: White þ 3 ∑Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. important: if item 27 is marked other then "nt eny injury or other treumetic event, Intermedia. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elizabeth Stader Don Leslie Livingston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Hansen Evans/Daughter 8510 60th Place, College Park, Maryland 20740 20b. Place of Disposition (Name of cometery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 St Cremation 3 ☐ Removal from State May 30, 2005 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral home/ Hethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician /Medical Due to (or as a consequence of): **Examiner** PNEUMONIA Sequentially list conditions, if any, leading to infinite solute cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ⚠No 24a. Was an has autopsy performed this certificate 2 **1**000 Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖫 No 1 Pripatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) nerel Director: After the filled in by the funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerei C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0057124 2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao, M.D., 13219 Executive Park Terrace, Germantown, Maryland 20874 31. Date filed (Month, Day, Year) MAY 3 I 2005 32. Registrar's Signature State Registrar

		-	For State Registrar	State of Maryland		artment of Hea		ental Hygie Reg.	211115	18051
	Physicia /Medic		1. Decedent's Name (First, Middle,	LISE Curring	Jraw	Hava	id 2	2. Date of Death Month	Day Year	3. Time of Death
	Examin	er	4a. Facility Name (If not institution, o	NusingtKelkk	certa	000000	ors ville	2 Batter of Birth	4c. County of Dea	erich
	Funeral Director		5. Social Security Number 423055419 Usual Residence of Decedent	Sex 1 M 2 F 7. Age (In yrs. la	Yrs.		ours Min.	Date of Birth (Month, Day, Ye	विष्ठ ।	thplace (State or Foreign punity)
	a-f show	ctor	10a. State 10b. County	serick Toc. City,	Town or Lo	erick				10d. Inside City Limits 1 ☐ Yes 2 No
	ath with the 23a or 28	Funeral Director	10e. Street and Number	lidge but was	7	10f. Zip Code 2176			Citizen of What C	7
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Department of the ZT is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Ever it with mast be indiffed at once.	by Fune	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 █ Divorced	12. Was Decedent Ever in U.S Armed Forces? d 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispar f Yes, specify Cuban, M 1 □ Yes 2 No Sp	nic Origin? (Spec fexican, Puerto Ri pecify:	rly Yes or No- ican, etc.)	14. Race - Am Black, Whi	te, etc.
21215-0036	within 72 ho ene. than "natur he Medical	Completed by	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 1 2		(Give	dent's Usual Occupation kind of work done durin DO NOT use retired)	n ng most of working	unk 16t	o. Kind of Business	Andustry unk
Maryland 2	uld be filed Jenta! Hygi irked other itic event, L	To Be Co	17. Father's Name (First, Middle, La Sydney Perryma					First, Middle, Maix Grace M		
, Mary	and 2 sho valth and 1 n 27 is me er traume		19a. Informant's Name/Relationship Patricia SHip			ng Address (Street and I 2. Addison Wo				Zip Code) 21704
Baltimore,	Pages 1 ament of He ent: If item ury or oth		20a. Method of Disposition 1. Burial 2 Cremation 3 4. Donation 5 Other (Spe	Removal from State ce	ace of Dispo emetery, crea	sition (Name of natory or other place)	Da	te 200	Location - City or	Town, State
Balt	Depart Depart Import any inj		21. Signature of Euneral Service Li	1/ Wee		State Anato Baltimore,	MD 212	01	Baltimo	
)	Physician		23a. Part 1. Enter the disease, or c shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	omplications that caused the death only one cause on each line.	urs urs	vosculur	acc as cardiac or	went arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner	Ŀ		b. Due to (or as a consequ	ral	fully	ton			months
, 0,	death certificate be executed e attending physician and ad for use as the buriat-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequ	ience of):					
ς 68760,	ertificate b ing physic e as the b	Medical	IF FEMALE:	d						
P.O. Box	that the death certific ed by the attending pl detached for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3[Ectopic pregnancy Other (specify)	-		23d. Date of de Month	livery Day Year
	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant condition	s contributing to death but not resu	alting in the u	nderlying cause given in	Part I.	23e. Did tobac	4	o the cause of death?
	: The law re cate has be page 2 shd	Completed					······	24a. Was an autopsy performed 1 Yes 2	? death?	utopsy findings available completion of cause of
f Vita	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? . 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatier		. Place of Death		e 6 □Other (Sp	ecify)
ion o	Attending Ph r death. ector: After th by the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	(Month, Day Year)	28b. Time o Injury	Work?	2 □ No	3d. Describe how	njury occurred	
Divis	sal or Attendi s after death. sl Director: A sd in by the fu	Certification:	3 Suicide 6 Could no determin		me, farm, st	reet, factory, office	28	Bf. Location (Stree City or Town, S		tural Route Number,
	To the Hospital or Atlending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying 2 Medical E	Physician: To the best of my know xaminer: On the basis of examinat and manner stated.	wledge, deat ion and/or in	h occurred at the time, ovestigation, in my opinio	date and place, ar on, death occurred	d at the time, date	and place, and du	e to the cause(s)
	To the within 3 To the Comple	Σ	29b. Signature and title of pertifier	7		DZ6	SIL	29d.	Date signed (Mon	th, Day, Year)
			30. Name and address of person	ho completed cause of death (Item		Print) 5 TA	WEY	Ne f	red pm)	>1762
	Sta Regist		31. Dale hied (Month, Day, Year) MAY 3 1.	2005 32. Registrar's Signat	ture	side!	,		3	

			State of Maryland / Dep	eartment of Health and Martificate of Death	Mental Hyg	iene g. No.	8052
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Deat Month	Day Year	3. Time of Death
	/Medic	al	Walter Nicholas Johns	4b. City, Town, or Location of Death	May 28	4c. County of Deal	5:35 PM
	Examin	er	4a. Facility Name (If not institution, give street and number) Brighton Gardens	North Bethesda	1	Montgon	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs.	8. Date of Birth		hplace (State or Foreign
b	Director	Į	154-16-1427 1X M 2□F 88 Yrs.	Months Days Hours Min.	Nov. 10	, 1916 Ne	w Jersey
	pug w		Usual Residence of Decedent 10c. City, Town or L 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Aaryk f sho	ъ	Maryland Montgomery North Be				1 ☐ Yes 2 X No
	r 28e-	rec	10e. Street and Number	10f. Zip Code	10	0g. Citizen of What Co	ountry?
	h with	a D	5550 Tuckerman Lane	20852		United St	ates
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "natural, or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give WWII	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- pecify Yes or No- pecify Yes	14. Race - Ame Black, Whit Specify: W	
2-0	72 ho natur jical j	eted	(Specify only highest grade completed) (Given	edent's Usual Occupation with kind of work done during most of work	kina	16b. Kind of Business/	Industry
2	vithin ne. han "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		D - 41-1 - 1-	
22	filed w Hygie ther t	CC	17. Father's Name (First, Middle, Last)	Salesman 18. Mother's Nam	ne (First, Middle, M	Bethlehen	Steel
and	ld be lental ked o	To Be	Nicholas Johns		th Schim		
ary	shoul nd Me rmari umati	Ě	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ling Address (Street and Number or Rui	ral Route Number,	City or Town, State, 2	Zip Code)
ž	and 2 alth a 27 Is er tra		Loretta M. Johns / Wife 5550	O Tuckerman Lane, N	lorth Bet	hesda, Mary	land 20852
ore	of He fiter		20a. Method of Disposition 20b. Place of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State	ematory or other place)		20c. Location - City or	
Ĕ	Pag ment tent: I		'4 □Donation 5 □Other (Specify)	Cemetery			ing, Marylan
Baltimore,	permit Depart Import any in		21. Signature of Funeral Service Licensee M01420 Rd	22. Name and Address of Facility Obert A. Pumphrey Fune OO West Montgomery Ave	ral Home/R nue, Rocky	ockville, In ille, Marylan	c. id 20850
П			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.		or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		resulting in death)	MONIA			G. Got and Boatt
L	Examiner		Due to (or as a consequence of):				
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				···
	cuted id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.				
ó	te be executed ysician and te burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):				
8760,	ate be hysici	licai	d				
.O. Box 68	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	by Physician/Med		□Ectopic pregnancy □ Other (<i>specify</i>)		23d. Date of del Month	ivery Day Year
О.	that the ed by detac	Ph	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ds,	uires signa Id be				1 □ Ye	s 2 9 No 3 □ Pr	obably 4 Unknown
Vital Records,	The lar	Completed			24a. Was ar autops perform 1 \(\text{Yes} \) 2	y prior to o	atopsy findings available completion of cause of
/ita	nding Physician: Th th.: After this certificate § funeral director, pag	Be	25. Was case referred to medical examiner?		th (Check only one	e)	
of	Physi this c	To	1 ☐ Yes 2 ☑ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie 7. Manner of Death 28a. Date of Injury 28b. Time		ome 5 Reside	nce 6 Other (Spec	pify)
no	ding h. After funer	tion	1 Natural 5 Pending (Month, Day Year) Injury	of 28c. Injury at Work? M 1 Yes 2 No	200. Describe no	w injury occurred	
Division	il or Attending after death. I Director: After d in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		28f. Location (Str City or Town	reet and Number or Ru , State)	ıral Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 1	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the ca	use(s) and manner as ate and place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29	Od. Date signed (Mont)	
	i		In Languas	P005712	4	5/29/	05
	5×1		30. Name and address of person who completed cause of death (Item 23a) (Type Truong Bao, M.D., 5622 Shields Drive,		d 20817	-3532	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 3 1 2005	k)			

Robert Julian 05-03692 crn

			1 - For State Registrar		Department of Health and Certificate of Death		ene 05	8053
	Physici	an	1. Decedent's Name (First, Middle, Last	7		2. Date of Death Month	Day Yeer	3. Time of Death
	/Medi		Robert		LIAN	May	29 2005	6:23 A ^M
7	Examir	ıer	4a. Facility Name (If not institution, give 221 S. Robinson S		4b. City, Town, or Location of Deat Baltimore	h	4c. County of Death	
	Funanci		5. Social Security Number 6. Se				9. Birthi	place (State or Foreign
	Funeral Director			N 107 - M 1	Yrs. Months Days Hours Min	APRIL 2	Year) Coul	seed salo
	р ,		Usual Residence of Decedent	10c. City, Town	n ar Leastine		* 12.	lost traits Situation
	anyla shov	5	M	Toc. Oity, Town	and the second s			10d. Inside City Limits 1 No 2 No
	the N	ecto	10e, Street and Number		BAltimore 101. Zip Code	10	og. Citizen of What Cou	
	3a or	Ö		NSON Street	of 21224		11 5	4
	death	by Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Americ Black, White,	can Indian,
98	or Ite	F	1 ☑ Never Married 2 ☐ Married	1 □Yes 2 ☑No If Yes, Give	1 ☐ Yes 2 ☐ No Specify:	to riloan, etc.)	Specify: \	1 ' /
5-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Iten Ezzara, not the Excitited at	q p	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edi	Year or Dates:	Decedent's Usual Occupation		6b. Kind of Business/In	hite
215-	n "na	Completed	(Specify only highest grad	de completed)	(Give kind of work done during most of wo life. DO NOT use retired)	rking		he of PARKS
212	d within giene. or than "	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	LAWN ENGI	Neer 0	5 BAlti	MORE City
	2 should be filled within and Mental Hygiene. Is marked other than aumatic event, ILUM.	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, M		. /
yla	Ment Ment arke	2	Albert		LIAN LAW,		TACHORE	
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23s or 28s-f show or other traumatic event, the Madical Entire actional tearwillied at	0.8	19a. Informant's Name/Relationship (T		. Mailing Address (Street and Number or R 703 Fait Avenue		City or Town, State, Zip	Code)
	1 and Health em 27	1	JOANNA K. FREUN 20a. Methodrof Disposition	20b. Place of	Disposition (Name of		20c. Location - City or To	own. State
jo	ages int of t: If it y or o		1 Burial 2 Cremation 3 :	Removal from State	ry, crematory or other place)			
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr. once.	H	21. Signature of Funeral Service Licens			C 22005 [THITIMONG	, I (May AN)
B	permit. Departrimportri) Charles	arini_	Joseph N. ZA	UNINO -	BAHO VI	SZIZZ4
П			23a. Part1. Enter the disease, or mp	cations that caused the death. Do no cause on each line.	not enter the mode of dying, such as cardia	or respiratory arre	st,	Approximate Interval Between
	Pnysician	8 0	Immediate Cause (Final disease or condition	Hypertensive Art	eriosclerotic Cardi	ovascular	Disease	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	of):			
Į-	LAUTHING	<u></u>	Sequentially list conditions,	b One to for sels noneaguerne	Mr			
	ited Insit	Examiner	d any, leading to in insulate cause. Enter Underlying Cause (Disease or injury	and to far an arran resignation	· · ·			\ \
Ć,	execu in and ial-tra	Exa	that initiated events resulting in death) Last	Due to (or as a consequence	of):			
8760	death certificate be executed e attending physician and of tor use as the burial-transit	dicai		d				
9	artifica ing pt e as t	Med	IF FEMALE:					
Вох	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death			23d. Date of delive Month	ery Day Year
0	e = ±	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)			
0		y Ph	Part II. Other significant conditions on	ontributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobe	ecco use contribute to t	ne cause of death?
Records,	requires tha een signed I nould be det	d by				1 🗆 Yes	s 2□No 3□Prot	ably 4 \Unknown
000	S 0 75	piete				24a. Was an		psy findings available
Re	The tree has bage	Completed				autopsy perform 1 Yes 2	prior to co led? death? XNo 1 ☐ Yes	mpletion of cause of 2☐ No
Vital	rding Physician: Th th. : After this certificate funeral director, pag	Bec	25. Was case referred to medical examiner?		26. Place of De	ath (Check only one		
of V	Physician: this certific ral director,	P	1X Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou			nce 6 Other (Specif	at scene
on C	Jing F After funera	ion:	27. Manner of Death 1 XNatural 5 ☐ Pending	(Month, Day Year)	Fime of njury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	w injury occurred	
Division	Attending r death.	ficat	2 Accident investigation 3 Suicide 6 Could not be			28f. Location (Str.	eet and Number or Rura	il Route Number.
Div	affer affer Dire	Certification:	4 Homicide	building, etc. (Specify)	, , ,	City or Town,	State)	
	the Hospital or Attenchin 24 hours after death the Funeral Director:				e, death occurred at the time, date and place d/or investigation, in my opinion, death occ			
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical	29b. Signature and title of certifier	and manner stated.	29c. License number		d. Date signed (Month,	
N	To To		290. Signature and title or certifier		OCME			
	A	1	30. Name and address of person who o	ompleted cause of death (Item 23a)		M	ay 29, 2005	
	10		ANA PUBIO	MD	111 Penn Street	Baltimo	ore, Maryla	nd 21201
		ite	31. Date filed (Month, Day Year)	32. Resistrar's Signature	Sparke			
	Regist	ali						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🕦 🕦 5 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Cleveland Joyner /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 46NE MORE If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country)
 11nk If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1**∑**M 2□F Months. Days unk 63 Director 220-36-9763 May 31, Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits 10b. County show Item 27 is marked other than "natural", or Itema 23e or 28a-f shov other traumatic event. The Medical Examinar must be notified at 1√ Yes 2 No Director Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21229 USA 22 S. Athol Avenue Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Itei 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: black 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk unk (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last, unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 S. Caton Avenue Baltimore, MD St. Agnes Heathcare 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Department of High Important: If Ite any injury or of once. cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ♥Other (Specify) in state 21. Signature of Funeral Service License 22. Name and Address of Facility Renald S. Wade, Director State Anatomy Board 655 W. B

Part I be the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 655 W. Baltimore Street Þ Approximate Interval Between Onset and Death Immediate Cause (Final Physician ASCVV LINKNOWN disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Nunknown neumonia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Sepsis page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 2 1 ☐ Yes 2 Ølo 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) filled in by the funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the To the 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

State

DOU53312

21229

MO

May

18, 2005

M

Sal +

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Caton Avenue

900

31. Date filed (Month, Day, Year)

MAY 3 1 2005

			State of Maryl 1 - State Registrer		artment of Health a	•	giene 005	18055
	Physici		1. Decedent's Name (First, Middle, Last) AGIE JUNIOR		KEEN	2. Date of De Month		3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, give street and number). The Johns Hopkins Hosp.	pitel	4b. City. Town, or Location of		4c. County of Dea	
	Funeral Director		0 - 11 0 7 1 1	yrs. last birthday) Yrs.	If Under 1 Year If Under 2 Months Days Hours	Min. 8. Date of Bir (Month, De Sept.	y, Year) C	thplace (State or Foreign ountry) irginia
	aryland show	J.	155. 51415	City, Town or Lo				10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	or 28a-1	Directo	10e. Street and Number	Baltimor	10f. Zip Code		10g. Citizen of What C	ountry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23c or 28a-f show any injury or other traumatic event, the Medical Exercities. Until to incilled at once.	y Funeral Director	7219 Waldman Avenue 11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever Armed Forces? 1 Yes, 2 No If Yes, Give		21219 Was Decedent of Hispanic Origit Yes, specify Cuban, Mexican □ Yes 2 No Specify:	jin? (Specify Yes or No , Puerto Rican, etc.)	U.S.A. 14. Race - Am. Black, Whi	
Maryland 21215-0036	ithin 72 hours 18. 18n "natural", 18ouinal Ex	Completed by	3 ☑ Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during most DO NOT use retired)	of working	16b. Kind of Business	,
and 21	ld be filed wental Hygier kad othar thice evant, Ins	To Be Cor	8 17. Father's Name (First, Middle, Last) William Keene	Load	18. Mother	r's Name (First, Middle		pany
Nary	2 shou and M is mar raumat	-	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Numbe	r or Rural Route Numb	er, City or Town, State,	Zip Code)
ore, N	es 1 and of Health fitam 27 r othar t		Stephen Keene(Son) 20a. Method of Disposition 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State	Ob. Place of Dispo	Waldman Ave., position (Name of matory or other place)	Date Date	20c. Location - City or	r Town, State
Baltimore,	rmit. Pag ipartment portant: I y injury o		`4 □Dopation 5 □Other (Specify) 21. Signature of uneral Service Lice see	Stiltner	rs Family Cem. 2 Name and Address of Facility 3 hortridge—Rame Route 460 West,	5/20/05 Ev Funeral	Stiltners	Creek, VA
8	8958		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not en	Route 460 West,	Grundy, V	A 24614	Approximate
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	i card	iomyopathy			Interval Between Onset and Death
8760,	Medical Examiner bhysician and bruial-transit	dical Examiner	Sequentially list conditions, if any, leading to monocular cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition of the cond	arten	y disease			16 years
 Box 6 	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as:	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of de Month	elivery Day Year
ds, P.O.	w requires that the bean signed by should be detact	d by Ph	Part II. Other significant conditions contributing to death but no Diabetes Mellitus	t resulting in the u	underlying cause given in Part I.		obacco use contribute t	to the cause of death?
Division of Vital Records,	The law requale has been page 2 shou	Somplete	myocardial infarction			24a. Was auto perfo 1 Yes	psy prior to death?	tutopsy findings available completion of cause of s 2 No
Vita	i cian: Th certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital:			of Death (Check only		
on of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, it	tlon: To	1 Yes 2 No Hospital: 1 Inpatient 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	2 ER/Outpatie 28b. Time o Injury		28d. Describe	dence 6 Other (Spe how injury occurred	ecify)
Divisi	al or Atter s after dea I Diractor id in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (S	At home, farm, st	reet, factory, office	28f. Location (City or To	Street and Number or F wn, State)	Rural Route Number,
	a Hospit n 24 hours a Funara letely fille	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my one) Certifying Physician: To the best of my one and manner stated.					
	To th within To th comp	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mon	
,	9		30. Name and address of person who completed cause of death	(Item 23a) (Type	Print\			
	Sta	ate	Eugene Fukudome, Johns Hopkins Harrital To 31. Date filed (Month, Dey, Year) 32. Physistran's S	Signature (Joans wange, 600	100 . Malde 21	, DAITIMONE,	1.100 d 5142 [
	Regist		MAY 3 1 2005	1 10 1	A CANCELLO AND A CANC			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 28^{Day} Decedent's Name (First, Middle, Last) Month May 2005 7:51 A M **Physician** Kaminski /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore
Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) Johns Bayview Medical Center
5. Social Security Number 6. Sex 7. Age (NA Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 1□M 2□F Yrs. 22 1953 Maryland Director 218-62-4377 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State "natural", or Items 23a or 28a-f ehow 1 Yes 2X No Maryland Baltimore Eastwood Directo 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21224 U.S.A. 7240 Bridgewood Drive Pages 1 and 2 should be filed within 72 hours after death Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced h and Mental Hygiene.
It is marked other than "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel 9 NA Laborer 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Bogdan Eleanora Kaminski 0 Α. Stanlev 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trau once. 7240 Bridgewood Drive Baltimore, Maryland 21224 Stanley A. Kaminski (Father) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State June 2,2005 Dundalk, Maryland 4 □ Donation 5 □ Other (Specify) Rosary Cemetery Holy 22. Name and Address of Facility 21. Signature of Furferal Service Lic W. Dabrowski/Ćhojnacki Funeral Homes P.A. 1005 Dundalk Ave. Baltimore, Maryland 21224 23a. Part1. hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death . Enter the disease, or complications c, or heart failure. List only one cau shock Immediate Cause (Final disease or condition resulting in death) Physician Aspiration Pneumonia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed **burial-transit** Due to (or as a consequence of): physician Box 68760. Completed by Physician/Medical the 23c. If yes, outcome of pregnancy 23d. Date of delivery for use 23b. Was decedent pregnant 2 Fetal death 3 DEctopic pregnancy Live birth Year Month Day in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, pe 1 Yes 2 No 3 Probably 4 Nunknown Rhabdomyolysis, Acute renal failure 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 1 🗌 Yes 26. Place of Death (Check only one) funeral director, To Be 25. Was case referred to medical examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: A death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 - Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific 4es-000 May 31,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Ave. Baltimore, Maryland 21224

RANIA B. ROSBOROUGH Johns Hopkins Bayview Medical Center RANIA B. ROSBOROUGH 2. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 3 1 2005 Registrar

		•	1- For State of Maryland /	Department of Certificate of		ental Hygien	4000	18057
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Francis Joseph Kielian	n	3	2. Date of Death	ay Year	3. Time of Death 4,45 AM
	Examin		4a. Facility Name (If not institution, give street and number) Baltimore Rehabilitation Extended	Care BAL	or Location of Death	4	c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 1 1 2	yrs. If Under 1 Year Months Days	r If Under 24 Hrs. s Hours Min.	B. Date of Birth (Month, Day, Yea CT . 3 , 1	9. Birthpl 921 MARY	lace (State or Foreign fry) LAND
	ould be filled within 72 hours after death with the Maryland Mental Hygiene. arked othar than "natural", or Itams 23a or 28a-f show atic evant, the M. dical Examinat must be motified at	tor	10a. State 10b. County 10c. City, Tot	wn or Location ALTIMORE			10	0d. Inside City Limits 1 XYes 2 No
	vith the	Direc	10e. Street and Number	10f. Zip Code		10g. C	Citizen of What Coun	try?
	ns 23s	eral	11 27 S. BONSAL STREET 11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of	21224 Hispanic Origin? (Speciban, Mexican, Puerto Ri	ify Yes or No-	U.S.A.	
920	urs after o al', or Itar Examiner	by Funeral Director	1 □ Never Married 2 ☑ Married I ☐ Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates: 1940 – 4	1 ☐ Yes 2 ☐ No		ican, etc.)	Black, White, e	etc. IITE
21215-0036	in 72 ho n *natur M. dical 1	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ia. Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	e during most of working	7 16b.	Kind of Business/Inc	dustry
212	ed with ygiene nar tha it, the	Com	9	PAINTER	40 44-15-4-41	1	THLEHEM	STEEL
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Itams 23a or 28a-f show any injury or othar traumatic evant, the Medical Examiner must be notified at one.	To Be	17. Father's Name (First, Middle, Last) JOHN KIELIAN		18. Mother's Name (GIZA		
Mar	od 2 sh Ith and 27 is m traum			9b. Mailing Address <i>(Stree</i>		_		
	of Hea of Hea fitam rotha		20a Method of Disposition 20b. Place	of Disposition (Name of tery, crematory or other pl	Da		Location - City or To	
Baltimore,	t. Pag rtment rtant: I		*4 □Donation 5 □Other (Specify) 21. Signature of Funeral Secrice Licensee	WOOD CEMET	ann of English			MARYLAND
Ba	permi Depa Impor any ir		1 College Hand	700 S. C	ZEILER IN CONKLING S	ST.,BALT	RAL HOME IMORE,MC	
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition		ving, such as cardiac or UnKNOWN	A /		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence		Divid Victoria	Ivino	/	
	Examiner	<u>-</u>	Sequentially list conditions, if any, leading to immediate	e ofi.				
7	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	,-				
8760,	icate be executed physician and s the burial-transit	cal Ex	resulting in death) Last Due to (or as a consequence	e of):				
9			0.					
. Box	death certifica e attending ph ed for use as tl	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death	th 3 Ectopic pregnan 5 Other (specify)	cy		23d. Date of delive Month	ry Day Year
P.O.	es that the death igned by the atte be detached for i	Phys	9 ☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting	s in the underlying cause s	ayen in Part I	23e Did tobacco	use contribute to th	e cause of death?
rds,	w requires the been signer should be a	by	Pattin. Other significant conditions contributing to death out not resulting	This disconying cause g	nvenili ratti.	1 ☐ Yes		
Records,	e lar has	Completed				24a. Was an autopsy performed?	prior to con death?	osy findings available inpletion of cause of 212 No
Vital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?		26. Place of Death (
of	Phys this al di	n: To	27. M n r of Death 28a. Date of Injury 28b.	. Time of 28c. Inj	other: 4 Nursing Home ury at 28	e 5 🗌 Residence Id. Describe how inj		<u>')</u>
sion	Attending ir death. actor: After by the fune	catlo	2 Accident investigation	M 1	□Yes 2□No			
Division	al or Att	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	e 28	If. Location (Street and City or Town, Sta	and Number or Rura. te)	l Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funaral Diractor: After completely filled in by the funer	edical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check only one) 2 Madical Exeminar: On the basis of examination a and manner stated.					
}	To th withir To th	Me	29b. Signature and title of certifier Lewise C. Wulls III I	- 0 0 1	H1365	1	Pate signed (Month, I	
	6×1		30. Name and address of person who completed cause of death (Item 23a George E. William 17.D. 3900		en Boulev	ard, Ba	iltimore,	MD. 21218
	° Sta Registr		31. Date filed (Month, Day, Year) MAY 3 1 2005					
			, , , , ,	-				

DHMH 17 Rev 1/2001

ORIGINAL

			1 - State of Maryland / Department of Health and Mei Certificate of Death		one 005	8058
	Physicia /Medic Examin	al	1 Decedant's Name (First Middle Last)	Date of Death	Day Year 3 7005	3. Time of Death 08!50 P.M
	Funeral Director	er *	BALTIMURE REHABILITATION EXTENDED CARE BALTII	Date of Birth (Month, Day, Y	ear) 9. Birthpla Count MD	ice (State or Foreign γ)
	ne Maryland 8e-f show	ector	10a. State 10b. County 10c. City, Town or Location			d. Inside City Limits 11 Yes 2 □ No
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Plygiene. Important: If item 27 is marked other than "natural', or Items 23a or 28e-f show any injury or other traumatic avent, the Medical Examinational be notified at once.	by Funeral Director	10e. Street and Number 603 S. Ann St. 11. Marital Status 1 ★Never Married 2 Married 11. Was Decedent Ever in U.S. Agned Forces? 1 ★Never Married 2 Married 1 ★Never Married 2 Married 1 ★Never Married 4 ★Never Married 1 ★Never Married 1 ★Never Married 1 ★Never Married 2 ★Never Married 1 ★Never Married 1 ★Never Married 1 ★Never Married 2 ★Never Married 1 ★Never	ט	. Citizen of What Count SA 14. Race - America Black, White, e Specify: Whit	n Indian,
Maryland 21215-0036	d within 72 hours giene. er than "natural"	Completed b	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		actory	
yland	nould be file I Mental Hyy narked othe natic avent,	To Be C	17. Father's Name (First, Middle, Last) Edward Leonard Christine	Cadde	n	Parifoli I
re, Mai	s 1 and 2 sh of Health and itam 27 is n other traun		Jennifer Ortiz (neice) 6678 Deeprun Pwkwy. 20a. Method of Disposition 20b. Place of Disposition (Name of Date	Elkrid		5
Baltimore,	permit. Page Department o Important: If any injury or once.		1X Burial 2 X Cremation 3 Removal from State '4 Donation 5 Other (Specify) 21. Signature of Fundal Service Livinsee 22. Name and Address of Facility Wesl 2007 Eastern Ave.	ey Cha	salto. MD	'H
	Priysician /Medical Examiner		23a. Part Enter the disease, or emplications that caused the reath. Do not enter the mode of dying, such as cardiac or resulting in death) a. Due to (or as a consequence of):		,	Approximate interval Between Onset and Death A 6 N THS
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):			
P.O. Box 6	death certifi e attending ed for use as	Completed by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) 9 \(\text{Unknown} \) Unknown		23d. Date of deliver Month	y Oay Year
	law requires that the as been signed by th 2 should be detache	ted by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PYLMONARY DISEASE		cco use contribute to the	
al Reco	The ate h page			·	prior to com	sy findings available pletion of cause of
Division of Vital Records,	Physrathis raldi	atlon: To Be			ce 6	
Divis	To the Hospitel or Attending within 24 hours after death. To tha Funeral Director: After completely filled in by the fune	Certification:		City or Town, S		
	To the Hospitel within 24 hours a To the Funeral Completely filled	Medical		at the time, date		he cause(s)
	· /		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	MA	7 24,2	005
	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AWRORA C. TAN 3900 LOCH RAVEN BOULEVARD BAI 31. Date filed (Month, Day, Seat) 2005 ARBEITH Signature	- 11 MOR	E,MD 2	1318

		•	For State Registrar	State Of Ma	-	cepartment of r Certificate of			No.	18023
	Physici /Medic		1. Decedent's Name (First, Middle, La	LEVI	NE			2. Date of Death Month 05_25 -	Day 7005 Yea	2:45 P.M
	Examin	er	4a, Fecility Name (If not institution, giv BALTI MIZE REHABI LI	e street and number) [ATI DN EXTENT	ED CAR		BALTI V	IORE	4c. County of D	N/A
	Funeral Director		5. Social Security Number 6. S 215-14-5809		(In yrs. last birt		If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day 7 05/14/1		Birthplace (State or Foreign Country) MD
	yland low		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Ba-f st	ctor	MD N/A	 	BALTIM					1 X Yes 2 □ No
	ath with th	Funeral Director	10e. Street and Number 524 N. CHARLES			10f. Zip Code 21201	" i- O-i-i-0 (O		U.S.	,
920	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23a or 28a-f show ther the Medical Examinat must be redified at	by	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🗖 No		o Rican, etc.)	Black, W	WHITE
15-0	n 72 h	Completed	15. Decedent's E (Specify only highest gr	ade completed)		Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of wor	rking	6b. Kind of Busine	ess/Industry
212	d withii giene. ar than	omp	Elementary/Secondary (0-12)	College (1-4or 5+	ME	TEOROLOGIST	*		U.S. GOV	ERNMENT
Maryland 21215-0036	ed ital	To Be C	17. Father's Name (First, Middle, Last BENJAMIN			LEVINE	FANNIE			SHAPIRO
Mar	s 1 and 2 should f Health and Men tem 27 is marke othar traumatic		19a. Informant's Name/Relationship (Mailing Address (Street '04 N. CHARL			-	e, Zip Code) E, MD 21218
	ges 1 and 2 it of Health if Item 27 or other tra	li	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [20b. Place of	Disposition (Name of y, crematory or other pla			c. Location - City	
Baltimore,	permit. Pages Department of Important: If It any injury or o		' 4 □ Donation 5 □ Other (Special	ý)	MD VET	ERANS CEMET	The second secon			
Bal	permit. Page Department Important: It any injury o		21. Signature of Fine of Service Lice	nsee		22. Name and Addre	50	L LEVINSO		., INC. ., MD 21208
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused one cause on each line	Э.	ot enter the mode of dyi	ng, such as cardia			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. PROBAB	LE U	ROSEPSIS	•			DAYS Onset and Death
	/Medical Examiner			Due to (or as a	consequence	of):				
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence	of):				
68760,	tificate be executed ig physician and as the burial-transit	edicai Exa	resulting in death) Last		consequence	of):				
	E O &		IF FEMALE:	23c. If yes, outcome of	of pregnancy				004 Para et	4-15
P.O. Box	The law requires that the death cert tte has been signed by the attendin, page 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	2 - Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of Month	Day Year
Vital Records, P.	quires that n signed build be deta	by	Part II. Other significant conditions HYPERTENS/0	contributing to death bu	t not resulting in	the underlying cause gr	ven in Part I.			e to the cause of death? Probably 4 Munknown
eco	e faw require has been si ge 2 should b	Completed	LEWY BODY I	DEMENTI	4			24a. Was an autopsy	24b. Were	a autopsy findings available to completion of cause of h?
a R	iclan: The l certificate ha rector, page		1	ATIC HY	PERT	ROPHY			ed? death	n? Yes 2∭ No
<u> </u>	ysiclan: s certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	nt 2 ER/Ou	tpatient 3 DOA Oth	hor .	ath <i>(Check only one)</i> Home 5 🗆 Residen	ce 6 □Other /5	Specify)
n of	ding Phy h. After thii funeral c		27. Manner of Death 1 ★Natural 5 □ Pending	28a. Date of Injury (Month, Day		Time of 28c. Injury Wo	ry at	28d. Describe how		
Division	r Attendii ter death. irector: Ai r by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not lead to determined	De Place of Inju	ry - At home, fa . (Specify)	m, street, factory, office	Yes 2 No	28f. Location (Stre City or Town,		r Rural Route Number,
۵	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	Medical Ce	29a. Certifier (Check only one) Check only one) Certifying P Certifying P Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination an	, death occurred at the ti	ime, date and place opinion, death occi	e, and due to the cau arred at the time, dat	se(s) and manne e and place, and	r as stated. due to the cause(s)
)	To the within 1 To the comple	Mec	29b. Signature and title of certifier	e. Tau	M	1. 29p-Licen	se number 4958	29°	Date signed (M	Joth, Day, Year)
	$/\!\!/ \times$		30. Name and address of person who AURO KA C > T 31. Date filed (Month, Day, Year) MAY 3 1 2005	completed cause of de AN 390	eath (Item 23a) 0 LOCK	Type, Print) PAVEN BO	ULEVAR	D BALTI	Mort,	MD 21218
		ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	ente				
DI	Regist	a .	WAY 3 T 2000	District .	~ ~	241643				

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

3 1 2005

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene) 1 - Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Vivian L. Leatherman 14, 2005 1:30 PM M May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11 W. Baltimore Street #524 Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year)
Dec 16, 1918 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1□M 2₩F Months Days 215-44-9574 86 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Exemptants. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 ☐ No Director MD Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21740 USA 11 W. Baltimore Street #524 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ŽĎ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 X Widowed 4 ☐ Divorced Be Completed unk unk 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emma Alberta Wilhelm Richard Curran Schleigh ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18807 Rolling Road Hagerstown, MD 21742 Judy Noland/neice 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal Irom State * 4 X Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee
Ronald S. Wade, Director
State Anatomy Board 655 W. B
Baltimore, MD 21201

23a. Partl. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. State Anatomy Board 655 W. Baltimore Street Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** UC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of): Examiner sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit or Attanding Physician: The law requires that the death certificate be executed thal initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. Il yes, outcome ol pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4 Pregnant al time ol death 5 Other (specify) 9 Unknown 9 Unknown Part II. D<mark>ther significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a, Was an After this certificate has autopsy performed' 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Najural 5 Pendina 1 ☐ Yes 2 ☐ No investigation after death 2 Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place ol Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel (To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 11110 Medical Campus Rd Hagerstown MD 2174Z 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Teresa M 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 3 1 2005 parte Registrar

			partment of Health and Menta	-	5 19062
			ertificate of Death	Reg. No:	0 10002
Physicia		1. Decedent's Name (First, Middle, Last) Thelma Louise Murray	2. Date Mon iM A		7ear 22:37 M
/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County o	
LAMITHI	C1	SINAL HUSPITAL OF BALTIMORE	BALTIMORE CITY		
Funeral		5. Social Security Number 6. Sex , 7. Age (In yrs. last birthdo	(av) If Under 1 Year If Under 24 Hrs. 8 Date	of Birth	9. Birthplace (State or Foreign Country)
Director		213–18–4839 1□M 2⊠F 85 Yrs			Maryland
)		Usual Residence of Decedent			
farylan show	Ę.	10a. State 10b. County 10c. City, Town of	Location		10d. Inside City Limits
se Ma 8e-f	cto	Maryland Caroline Denton			1 No 2 No
vith th	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of Wr	nat Country?
ath v		401 Riverview Gardens	21629	USA	
er de item	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Armed Forces? 1 □ Yes 22 No	 Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e 	tc.) 14. Hace Black,	American Indian, White, etc.
36 rs aff	by F	3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 No Specify:	Specify:	
5-0036 72 hours aft naturel', or	ed	15 Decedent's Education 16a De	cedent's Usual Occupation	16b. Kind of Bus	Black iness/industry
215 215 86 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	pie	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of working a. DO NOT use retired)		,
212 213 30 will 90 will 90 the	Completed		e Worker	Carolin	e Poultry
Ind 21215-0036 be filed within 72 hours after death with the Maryland Ital Hygiene. d other then "naturel", or items 23s or 28e-f show event, I've Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, I	Middle, Maiden Sumame,	}
arylai should b ind Menti marked	10	Herman Murray	Linnie	Saderf	ield
		19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ailing Address (Street and Number or Rural Route	Number, City or Town, S	tate, Zip Code)
ore, M ss 1 and 2 of Health item 27 i			.O.Box 194, Bridgeville	, Delaware	19933
Baltimore, occurrence, occurre		20a. Method of Disposition 20b. Place of Discometery, 6	sposition (Name of Date place)	20c. Location - C	ity or Town, State
Baltimore permit. Pages: Department of h Inportent: if ite arry injury or of		1 Define 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify) Sprine	Grove Cem. 05/21/200	5 Denton.	Maryland
Balt permit. Departr in ports arry inji		21. Signal of Yur eral Cerville Licenses	22. Name and Address of Facility		
, D 970 = 99		The succession	Bennie Smith Funeral 426 Dover Street, Ea	ston, Maryla	nd 21601
		23a. Part 1. Ever the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.			Approximate Interval Between
Physician	8 1	Immediate Cause (Final disease or condition Multiple One)	Failore		Onset and Death
/Medical		resulting in death) Due to (or as a consequence of):	0 11 12 12 12 12 12 12 12 12 12 12 12 12		100000
Examiner		Sequentially list conditions b. Sep 575			(will.
P #	Iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury			1
ecute and -trans	Examiner	Causes (Disease or Injury that initiated events resulting in death) Last C. Wetz State Over the Country of the	ian cancer.		1 month.
760, te be executed ysician and e burial-transit		Due to (or as a consequence of):			
- w 5 0	dicai	d			
Box 6876 Jeath certificate b attending physic	Physician/Medi	IF FEMALE: 236. If yes, outcome of pregnancy			
Box eath cert attending for use a	ian	in the past 12 months?	3 Ectopic pregnancy	23d. Date Montl	
P.O.	ysic	1 Yes 2 No 9 Unknown	5 Other (specify)		
P.O. I		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I. 23e	. Did tobacco use contrib	ute to the cause of death?
ds uires uires ld be	d by	Chronic obstructive pulmonary disease, conqu	stre heart Anture,	1 Yes 2 No 3	☐ Probably 4 ØUnknown
cords, P	Completed		-	. Was an 24b. We	ere autopsy findings available
Rec ne lav s has ge 2 s	mp		240	autopsy pri- performed? de-	or to completion of cause of ath?
Division of Vital Records, or attending Physicien: The law requires that director: After this certificate has been signed in by the funeral director, page 2 should be control.		OF Was and relevant to modified		Yes 22 No 1	Yes 2 No
Vit sicie certi	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death (Check		
Of Phys r this rral dir	-	27. Manner of Death 28a. Date of Injury 28b. Time	tent 3 DOA 4 Nursing Home 5	J Residence 6 ∐Other cribe how injury occurred	
On C iding P th. After t	Certification:	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injur 2 ☐ Accident investigation		,,,,,	
Divisio	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,	street, factory, office 28f. Loca	ition (Street and Number	or Rural Route Number,
Div after Dire	erti	4 ☐ Homicide determined building, etc. (Specify)	City	or Town, State)	
spite sours nerel		29a. Certifier 12 Certifying Physician: To the best of my knowledge, de	eath occurred at the time, date and place, and due	to the cause(s) and mann	ner as stated.
e Ho 24 t e Fu letely	ledical	(Check only 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred at the	time, date and place, an	d due to the cause(s)
Division of Vital Records, P.O. Box 68 To the Hospitel or Attending Physicien: The law requires that the death certifical within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		lyn. in.o.	KES - 000	MAY 1	4,2005
5		30. Name and address of person who completed cause of death (Item 23a) (Typ			
		YING WEI LUM, M.O. SINA	HOSPITAL OF BALTIMO	RE.	
Sta		31. Date filed (Month, Day, Year) 32. Fegistrar's Signatury	lospital OF BALTIMO		
Registr	ar	MAY 3 1 2005			

		4	_ State	State of Marylar		rtment of F		_	200)5	18063
Phy	sicia	n	Registrar 1. Decedent's Name (First, Middle, Last)	Robert	- T	MAG	Lan	2. Date of De Month	Reg. No. ath Day	Yeer	3. Time of Death
/M	edica mine	al -	4a. Facility Name (If not institution, give str	Λ	6	4b. City, Town, o	r Location of Dea	1 / 1		2005 nty of Death)
Fune			5. Social Security Number 6. Sex	7. Age (In yrs.	/	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, Da	th ly, Year)	9. Birth	place (State or Foreign intry)
Direc			488-28-2940		ty, Town or Lo	eation		APR 25,	1922	Miss	OUCI 10d. Inside City Limits
he Maryli 8a-f sho		Director	Maryland Baltimore	!		1	imore		40.000		1 ☐ Yes 2 No
with t			3320 Benson Avenue			10f. Zip Code 21227	7		10g. Citizen o	f What Cou	intry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any initive or what fraumatic seen.		by Funeral		2. Was Decedent Ever in U Armed Forces? 1 X Yes 2 No If Yes, Give 45 —4 Year or Dates: 51 —	46			Specify Yes or No rto Rican, etc.)	USA 14. Ri Bi	ace - Ameri lack, White city: Wh	
within 72 hou sne.		Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	16a. Deced (Give life. L	ent's Usual Occup kind of work done OO NOT use retire OTNEY	oation during most of wo d)	orking	Josep	h E.	ndustry Seagrain
uld be filed v fental Hygierked other i		To Be Co	17. Father's Name (First, Middle, Last) David Joseph McKay	5+ y, Jr.	Acc	orney		me (First, Middle) .ma Byrd	, Maiden Suma		
and 2 shou ealth and N m 27 is man			19a. Informant's Name/Relationship (Type Robert James McKay,			Address (Street Daisy R		dural Route Numb odbine, Iv			ip Code)
Pages 1 at the part of Heal int: If item			20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State	Place of Dispos cemetery, cren	sition (Name of atory or other place	ce)	Date	20c. Location	n - City or T	
permit. P Departme Importan	once.		21. Signature of Euneral Service bicensee		Cre	ematory, Name and Addre	ss of Facility Society	of MD I Baltimo	Baltin nc.		
Physici	an		23a. Part1. Enter the diseased, or complicion shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the dea						.2124	Approximate Interval Between Onset and Death
/Medic Examir	ier		resulting in death) Sequentially list conditions, b.	Due to (or as a cons-	arkı	'nson'	s D	is eas	e		V-ears
The law requires that the death certificate be executed ate has been signed by the attending physician and the change of should be detached for use as the burial transit.		al Examiner	if any, leading to immediate cause. Enter Undertyling Cause (Disease or injury that initiated events causiting in death) Last c.	Due to (or as a consec							-
ertificate ing physical		Medical	d.				1.50				
that the death certification of by the attending of		Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a 9 ☐ Unknown	al death 3	Ectopic pregnancy Other (specify)	y			Date of delive	very Day Year
requires that sen signed be detailed to detail the details.		ò	Part II. Other significant conditions conti	ributing to death but not res	sulting in the ur	derlying cause giv	ven in Part I.		obacco use co Yes 2 □ No		the cause of death?
vician: The law requires that the discretificate has been signed by the	, page 1	Completed						1 Yes	ormed? 2 No	prior to co death? 1 \(\sum Yes\)	opsy findings available ompletion of cause of
Sician:		o Be	25. Was case referred to medical examiner?	spital: 1 Inpatient 2	ER/Outpatien	317 DOA Ott	100	ath <i>(Check only c</i> Home 5 ☐ Resi		thor (Case	(4.1)
ding Phys h. After this	Gildia	H	27. Manner of Death Natural 5 Pending Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui Woo	y at	28d. Describe			
To the Hospital or Atlanding Physician: The Atlant 24 hours after death. You he Thomara Director: After this certificate his considered in the funder of the control of th	an in con inse	Certification	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre	eet, factory, office		28f. Location (. City or Tou	Street and Nun wn, State)	nber or Rur	ral Route Number,
ne Hospit n 24 hour ne Funera	pletery IIII	Medical	29a. Certifier (Check only one)	cien: To the best of my known: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the tile estigation, in my o	me, date and place opinion, death occ	e, and due to the curred at the time,	cause(s) and r date and place	nanner as :	stated. to the cause(s)
To the tithing the		Σ	29b. Signature and title of certifier	ny	mo	29c. Licens	se number)	29d. Date sign	3 I	2005
15	1		30. Name and address of person who com	pleted cau dean (ite	m 23a) (Type, I	Print)	Balt	imove	Mar	ryla	nd 2/22,
Red	Stat		31. Date filed (Month, Day, Year) MAY 3 1 20	32. Pogistrar's Sign	ature	ask s				/	

			1- State of Maryland / Department / Departmen	artment of Health and M rtificate of Death		ene 2005	18064
	9		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
н	Physici /Media		Adele Frances McKaig		May 28,	2005	12:45 PM
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
п			Manor Care Ruxton	Towson		Baltimo	re
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birth	nplace (State or Foreign untry)
Ш	Director		056-03-4014 1 N 2 F 103 Yrs.			1901	lew Jersey
	and * *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
	Aaryli Sho	ō	MD Baltimore Towson				1 ☐ Yes 2X No
	28a-	Director	MD Baltimore Towson	10f. Zip Code	100	. Citizen of What Co	
	with	٥	800 Southerly Road #120	21286	""	USA	311u y :
	death with the Maryland ms 23a or 28a-f show rmst be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - Amer	ican Indian,
٥	or Itar	Fur	Armed Forces? 1 X Never Married 2 Married 1 Yes 2 X No	I Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	
9500-61212	be filed within 72 hours after death with the Manylan tal Hygiene. d other than "natural", or Itams 23a or 28a-f show event, i're Medical Ever at most be notified at	b	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 □ Yes 2 🔃 No <i>Specify:</i>		Specify:	White
r C	72 hand	Completed		dent's Usual Occupation kind of work done during most of worki	16	b. Kind of Business/I	ndustry
7	within 72 ene. than "nai	Jdu	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)			
	filed w Hygier other ti			rvisor			AT & T
and		Be	17. Father's Name (First, Middle, Last)		(First, Middle, Ma.		
>	should ind Men inarke umatic	10	James Joseph McKaig	Fannie	Teresa	Sutton	
Mar	12 shoth and 7 is muttraum			ng Address <i>(Street and Number or Rura</i> Governors Way Nort			
	ges 1 and 2 should it of Health and Mer If item 27 is marke or other traumatic		20a. Method of Disposition 20b. Place of Dispo			c. Location - City or 1	
Baitimore,	permit. Pages Department of I Important: If it any injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crei	natory or other place)	1	•	
	artme orteni injury			Cemetery 06/0	3/2005 N	Metuchen,	New Jersey
g	permit. Departr Importe any inju		Musik D. S. Coster 10	2. Name and Address of Facility Ruc 050 York Road, Tow	con Mary	runeral H	ome, inc. 1204
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent				Approximate
			shock, or heart failure. List only one cause on each line.		•		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	tructive lung	91320	SE	
	Examiner		Charantic	structure lung	11 ation		
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	7000			
7	uted d ansit	Examiner	Cause (Disease or injury that initiated events c.	571			
Ď	death certificate be executed e attending physician and of for use as the burial-transit		resulting in death) Last Due to (or a la consequence of):				
8/PU	ite be nysicii	dicai	d				
٥	ng ph as th		IF FEMALE:				
X Q Q	th ce tendii	Iclan/Me	23b. Was decedent preopert 23c. If yes, outcome of pregnancy	Ectopic pregnancy		23d. Date of delin	•
	e dea he at ved fo	200	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month	Day Year
7.	res that the death certific igned by the attending p be detached for use as	Phys	9 - Onknown		on Didasti		
Š,	requires that the een signed by th hould be detache	by	Part II. Dther significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		couse contribute to 2 □ No 3 □ Pro	
Hecords	w require been sig should t	ompleted			10 105	2 No 3 Pro	bably 4 🗹 Unknown
၁	a faw	nple			24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
	sician: The law s certificate has b irector. page 2 s	Cor			performed 1 ☐ Yes 2 ☑		2 No
VItal	ysician: is certific director.	Be	25. Was case referred to medical examiner?	26. Place of Death			
0	> 0 0	6	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien			e 6 Other (Spec	ify)
	ling f	lon	27. Mannof of Death 1 ☐ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 1 ☐ Injury	Work?	28d. Describe how	injury occurred	
<u>s</u>	ttenc death stor: the	icat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	28f Location /Ctmo	at and Number or Rui	m I Doute Alumbas
UNISION	or A after Direct in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, str	eet, factory, office	City or Town, S	State)	ar noute Number,
	spital		29a. Certifier 1 E Certifying Physicien: To the best of my knowledge, death	occurred at the time, date and place a	and due to the caus	ee/s) and manner as	etated
	24 h 24 h e Fur etely	edical	(Check only 2 Medicel Exeminer: On the basis of examination and/or in one)	restigation, in my opinion, death occurre	ed at the time, date	and place, and due	to the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Me		29c. License number	29d.	Date signed (Month	Day, Year)
	2 - 0		1	752749		05/31/2	5
	_		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)			
	15		J. HIRPARA MB. 7505 Usler	Print, Suite 50	9, Tow.	sor, me	21205
	A Sta	ite	31. Date filed (Month, Day Year) 2005 Registrar's Signature	Als I			
	Registr	rar	INIMI OT COOL MINE IN. MAN				

1 - For State Registrar	Stat	e of Maryland		nent of Health a cate of Death	and Mental H	ygiene (05	18065
1. Decedent's Na	me (First, Middle, Last)				2. Date of I	Death		3. Time of Death
Physician RICH	ARD GRI	EGORY	M06	AVERO	Month	30	2005	7:30 A M
	(If not institution, give street ar			City, Town, or Location of		4c. Co	unty of Death	
Baltimo				Saltimo:		Λ	17	(0)
Funeral 5. Social Security 218-10-6	308 ¹₩™ ²□	7. Age (In yrs. las		nths Days Hours	Min. MAY 1	9ay, Year) 4, 1923	9. Birthpi Coun Mary	lace (State or Foreign try) Land
Usual Residence 10a, State	of Decedent 10b. County	10c. City,	Town or Location				11	0d. Inside City Limits
10a. State Maryland	N/A			Baltimore				1∑Yes 2□No
10e. Street and N			10	f. Zip Code		10g. Citizer	of What Coun	try?
10 656 Col	eraine Road			21229		USA		
Maryland 10e. Street and N 10e. Street and N 11. Marital Status 11. Never Ma	12. Was	Decedent Ever in U.S. ed Forces?	13. Was I	ecedent of Hispanic Original Specify Cuban, Mexican	gin? (Specify Yes or !	No- 14.	Race - Americ Black, White,	
S start	- 14-475	Yes 2 □ No es, Give ror Dates: 1941 – ∠	1 1 Y	es 2 No Specify:		Sp	ecify: Whi	
22 hor	15. Decedent's Education ecify only highest grade compl		16a. Decedent's	Usual Occupation of work done during most	of working	16b. Kind	of Business/Inc	lustry
Completed (Sp. 12)		ege (1-4or 5+)	life. DO N	OT use retired)	or working	Rest	aurant	
Description of the state of the	e (First, Middle, Last)		Restau	ranteur	r's Name (First, Mida			
8 <u>a 8 8 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 </u>	Mogavero				atherine B		,	
bush of signature of Joseph 19a. informant's	Name/Relationship (Type, Prin			dress (Street and Numbe		•	wn, State, Zip	Code)
Suzanne	Mary Mogavero			eraine Road		1	21229	
20a. Method of D Set of the particle of the	2 XCremation 3 □Removal	from State Cen	ce of Disposition netery, crematory	or other place)	Date		ion - City or To	
4 Donation	5 ☐ Other (Specify) Funeral Service Licensee	Metr		tory, Inc.		Balti	more, 1	MD
21. Signature of Lichweight	uno A. Jan	ll	Cres	ne and Address of Facility Stion Socie Frederick R	ty of MD.	Inc.		
23a, Part1, Enter	r the disease, or complications eart failure. List only one cause	that caused the death.	Do not enter the	Frederick R mode of dying, such as	OSG FSITI cardiac or respiratory	ore, li	D 212 28	Approximate Interval Between
Physician Immediate Caus disease or condition	e (Final	conal 4	Failure					Onset and Death
/Medical resulting in death	a	ue to (or as a conseque						
Examiner Sequentially list of if any, leading to	conditions, b.	ue to for an a company	nao ofti					
	derlying or injury	ue to (or as a conseque	nce or).				5	
ff any, leading to	nts c	ue to (or as a conseque	nce of):					
Carse (Disease that initiated every content of the purial transit	d							
Med it lead to the state of the			541 HT.					
atte pue la contra de la contra del contra de la contra del la contra de la contra de la contra de la contra de la contra del la	2 months?	s, outcome of pregnance Live birth 2 Petal d	eath 3□Ecto	oic pregnancy		23d	Date of deliver Month	ry Day Year
in the death certific in the past of the p	Z LI NO	Pregnant at time of dea Unknown	tn 5 Ll Otne	r (specify)				
Part II. Other sign	nificant conditions contributing	g to death but not result	ing in the underly	ing cause given in Part I.	23e. Dio	tobacco use	contribute to th	e cause of death?
w requires the requires should be sh	rtension				1,5	¶Yes 2□N	o 3 ☐ Proba	ably 4 Unknown
The law requirements are the same of the s	setes				24a. Wa	as an 2	prior to con	psy findings available appletion of cause of
25. Was case and complete has been director. The taw					per 1 ☐ Yes	rfórmed? 2.X.No	death? 1 🗌 Yes	
25. Was case ref	Hospital			0.1	of Death (Check only			
25. Was case ref examiner? 1	X INO	Date of Injury 2	8b. Time of	28c. Injury at Work?	rsing Home 5 Re	sidence 6 🗆 e how injury of)
Tage 1 Matural 2 Accident	5 Pending investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ N	No			
The state of the s	6 Could not be determined 28e.	Place of Injury - At hom building, etc. (Specify)	e, farm, street, fa	ctory, office		(Street and N own, State)	umber or Rural	Route Number,
	1 Certifying Physician:	To the best of my knowl	edge, death occu	rred at the time, date and	place, and due to th	e cause(s) and	d manner as sta	ated.
29a. Certifier (Check only one)	2 Medical Examiner: On	the basis of examination I manner stated.	anwor investig	аноп, из ту ориноп, ават	in occurred at the time	, uate and pla	oo, and due to	ine Gause(S)
				29c. License number		29d Data ei	aned /Month /	Day Year
F 3 F 3	and title of certifier	(n. N 1: -		29c. License number	71-	29d. Date si	gned (Month, L	Day, Year)
$\langle \rangle$	nd title of certifier	edmo	3a) (Type Print)	P185	74	May	30	,2005
$\langle \rangle$		edmo	3a) (Type, Print)	29c. License number P185 Greene	74 St. Roon	May	30	,2005

Physician	1	Strate Unpend Item Registramend item Decedent's Name (First, Middle, Le	#8 per	th 2844	STIP STIP OF DAY	th 2. Date	Reg. No.		3. Time of De	ath
		Dean Alto	231/			Mont Ma	h Day	y Year		р ^М
/Medical Examiner	4	a. Facility Name (If not institution, gir	ve street and number)		4b. City, Town, or Locati			County of Death	7.74	
Lxammer		North Bound Interstat	e 95 at Mile	Marker 82	Aberdeen			Harford		
Funeral Director	5		Sex 10 AM 2□ F	6 (In yrs. last birthda) 59 Yrs.	Months Days Hou	irs Min. 8. Date (Mon	of Birth th, Day, Year) 24,1945	9. Birth Cou Gilm	place (State or Fo intry) Bn,VT	reign
D *	-	Usual Residence of Decedent Oa. State 10b. County		10c. City, Town or	Location	AFK			10d. Inside City L	imits
with the Maryle or 28a-f sho be notified ut			dsor	Brid	gewater				1 X Yes 2[□No
death with the Maryland ms 23a or 28a-f show rmust be notified at neral Director	1	Oe. Street and Number Mill Apartmen	ts #3		10f. Zip Code 05034			tizen of What Cou USA	intry?	
2 2 2 E	1	1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		Was Decedent of Hispanic If Yes, specify Cuban, Mex		or No- c.) unk	14. Race - Ameri Black, White, Specify: Wh		
ed within 72 hou vgiene. Vgien	-	15. Decedent's E (Specify only highest gi	Education rade completed) College (1-4or 5	(Gir	eedent's Usual Occupation we kind of work done during . DO NOT use retired)	most of working		ind of Business/Ir Shipping	ndustry	
nd 2 should be filed within 72 hours after the and Mental Hygiene. 27 Is marked other than "natural", or traumatic event, the Medical Exam. To Be Completed by F	3	12 17. Father's Name (First, Middle, Las George McBey			Truck Dřiver	flother's Name (First, A	Middle, Maiden	n Surname)	1	unl
nd 2 should be lith and Mental 27 is marked (2 r traumatic ev		19a. Informant's Name/Relationship Kimberly Townse	* ** *		iling Address (Street and No Webster Road				p Code)	
oermit. Pages 1 and 2 Department of Health mportant: If Item 27 I any Injury or other tra ance.	1	20a. Method of Disposition 1 Burial 2 Commation 3 Commation 3 Commation 5 Other (Specific Property of the Commation Series of		cemetery, ci	position (Name of rematory or other place) w Crematory	May 23, 2005		ocation - City or T .timore M		
permit. Pages Department of Important: If I any Injury or once.	ľ	21. Signature of Funeral Service Lice	esene		22. Name and Address of F Charles L. S 1501 Fast Fo	acility tevens Funera rt Ave Baltin	il Home I	Inc. 21230		
Cal Examiner	מון דעמוווו	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	b	a consequence of): a consequence of): a consequence of):	herosclerotic	Cardiovas	cular	DIsease		
es that the death certificate gned by the attending phys be detached for use as the by Physician/Medic:	yalcıdırını	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 Dectopic pregnancy 5 Other (specify)			23d. Date of deliv Month	very Day Yea	ır
uires that the de signed by the a ld be detached f		Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause given in F	Part I. 23e		use contribute to	the cause of deal	
ician: The law requires that the certificate has been signed by the ector, page 2 should be detache. Be Completed by Phys						10	. Was an autopsy performed? Yes 22 No	prior to death?	opsy findings ava ompletion of caus	
	2	25. Was case referred to medical examiner? 1 X Yes 2 No 27. Manner of Death 1 X latural 5 Pending investigat 2 Accident investigat 3 Suicide 6 Could not determine	28a. Date of Inju (Month, Da	ury - At home, farm,	ient 3 DOA Other: 4[2 □ No	Residence scribe how inju	nd Number or Rui		300
ttending Physician: death. ctor: After this certific y the funeral director.	Call		building, et	c. (Specify)		City	or Town, State	Θ)		
or Attending Physical death. Iter death. In by the funeral direction: To	- Ceruncan	4 Homicide	Discolate T	1 - 1 - 1 - 1	- de la companya de l	to and place on the	to the second	\ and man===	stated	
the Hospital or Attending Physician in 24 hours after death. The Luneral Director: After this certification by the funeral director death.	ealcai	29a. Certifier (Check only one) 1 Certifying 1 2 Medical Ex	Physician: To the best aminer: On the basis o and manner st	f examination and/or	eath occurred at the time, da	, death occurred at the	time, date an	d place, and due	to the cause(s)	
an series C	ealcai	29a. Certifier 1 Certifying Check only 2 Medical Ex	aminer: On the basis of	f examination and/or	29c. License num	, death occurred at the	29d. Da	s) and manner as d place, and due ate signed (Month	to the cause(s)	
To the Hospital or Attending Physician within 24 hours after death. To the Funeral Director: After this certification: Accompletely filled in by the funeral director Medical Certification: To Be	ealcai	29a. Certifier (Check only one) 1 Certifying 1 2 Medical Ex	aminer: On the basis of and manner st	of examination and/orated.	29c. License num OCME	, death occurred at the	29d. Da	ate signed (Month	to the cause(s) , Day, Year)	

			For Stata Registrar	State of Ma	aryland /	-	artment of H		nd Mer		ene) ()	5 1	8067
1.00	Physici	an	1. Decedent's Name (First, Middle, Las		161	M · 1	1		2.	Date of Death	Day	Year _	3. Time of Death
	/Medic	al	de Caller Manager		1fred	Mi1		1	D	5 0		.005	1.3/PM
	Examin	er	4a. Facility Name (If not institution, give	A 11	Pita	1	4b. City, Town, or	_ 1 1	P		4c. County	1 4	MACP
	Funeral		5. Social Security Number 6. Se	x 7. Ag	e (In yrs. last		If Under 1 Year	If Under 24	Brown .	Date of Birth (Month, Day,	160	9. Birthpl	ace (State or Foreign
ш	Director		213-22-9212	3x ^{M 2□ F} 7	8	Yrs.	Months Days	Hours	Min. Ja	anuary	8, 192	27 Mar	ryland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation					10	Od. Inside City Limits
	Maryl 1 sho	tor	Maryland N/A			В	altimore						XXYes 2 ☐ No
	r 28s	irec	10e. Street and Number				10f. Zip Code			10	g. Citizen of	What Coun	try?
	th wit	Funeral Director	525 W. 27th Street					21211	l			USA	
	er dea	uner	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Decedent of H f Yes, specify Cuba	ispanic Origir In, Mexican, I	n? (Specify Puerto Rica	Yes or No- an, etc.)		e - America ck, White, e	
36	irs afte	by F	1 ☐ Never Married 2	1x□xYes 2 □ 1 If Yes, Give Year or Dates:	WWII	ļ	1 ☐ Yes 2/CXNo	Specify:			Specif	y: TA	hite
9	d within 72 hours after death with the Maryland jiene. r then "naturel", or Items 23e or 28e-f show the Miscleal Examinar must be notified at	ted	15. Decedent's Ed	ucation	1		dent's Usual Occup		4 4 - 2	1	6b. Kind of B		
215	within 7 ene. then "r he Med	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	i+)	life.	kind of work done of DO NOT use retired	1)	or working				
121	a filed w I Hygier other th		5th 17. Father's Name (First, Middle, Last)			Ma	nufacturi		o Namo (E		America Maiden Suman		Company
anc	be de la be	o Be	John A. Miller						ry Ele		alderi Suman	10)	
Maryland 21215-0036	S P E E	To	19a. Informant's Name/Relationship (7	ype, Print)	1	9b. Mailir	ng Address (Street a	and Number	or Rural Ro	oute Number,	City or Town,	State, Zip	Code)
	01 00 00 00		Douglas L. Miller	Son		525	W. 27th S	treet	Ва	altimor	ce, Mar	yland	21211
ore	# O b-		20a. Method of Disposition XXSurial 2 ☐ Cremation 3 ☐	Removal from State	ceme	tery, crei	sition (Name of matory or other place	(e)	Date		0c. Location -	-	
Baltimore,	Pages tment of tant: If it		' 4 □Donation 5 □ Other (Specify)	Lake		w Memoria		5/28	3/05 E	Eldersh	urg,	Maryland
Bal	permit. Page Department of Important: If any injury or once.		21. Signature de uneral Se ride Licent	meter	- 1	B 3	: Name and Addres urgee—Hen 631 Falls	ss of Facility .ss- Se . Road	eitz I Bal	[unera]	Home,	Inc.	21211
			23a. Part 1. Enter the disease, or compositions, or heart failure. List only of	lications that caused one cause on each lin	the death. D	o not ent	er the mode of dyin	g, such as ca	ardiac or re	spiratory arre	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Pneum	ionia							1	Onset and Death
	/Medical Examiner		resoluing in dealth)	Due to (or as	a consequenc	ce of):							/
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequenc	e of):			<u>-</u>				
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	С.									
,00	e exe ian ar urial-t		resulting in death) Last	Due to (or as	a consequenc	e of):						- 1	
8760	death certificate be executed e attending physician and id for use as the burial-transit	dicai	•	d								-	
9 X	death certifica attending ph d for use as t	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy						23d Da	te of deliver	24
Box	death a atter d for u	Iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at	2 Fetal dea		Ectopic pregnancy Other (specify)						y Day Year
P.0	res that the de signed by the a I be detached f	Physician/Med	9 Unknown	9□ Unknown	-						İ		
	law requires that the as been signed by th 2 should be detache	by F	Part II. Other significant conditions co	ntributing to death b	ut not resulting	g in the u	nderlying cause give	en in Part I.			-		e cause of death?
ord	v require been sig should b	Completed	Wroselsis						_	1 🗌 Yes			ıbly 4 □Unknown
3ec	e law has b je 2 si	mple	Ileus						_	24a. Was an autopsy perform	1 1	Were autop prior to com death?	sy findings available apletion of cause of
la	iclan: The Certificate harector, page	e Co	25. Was case referred to medical					00 51	15 11 10	1 ☐ Yes 2	Z No		2 🗆 No
Ž	S 0 10	0 8	examiner?	Hospital: 1 Zînpatie	nt 2 ER/	Outpatier	t 3 DOA Othe	200		heck only one 5 □ Resider	nce 6 Oth	er (Specify	1
0	ding Phys h. After this funeral di	Ju: T	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju	y 28t	Time of					w injury occur		
siol	Attending r death. sctor: After by the funer	catic	2 ☐ Accident investigation					Yes 2 □ No	0				
Division of Vital Records,	after d Direct J in by	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ury - At home, c. (Specify)	farm, str	eet, factory, office		28f.	Location (Stre City or Town,		er or Rural	Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A Completely filled in by the fu	edical C	29a. Certifier Check only one) Certifying Phy	rsician: To the best of iner: On the basis of and manner sta	examination	ige, deatl and/or in	n occurred at the time vestigation, in my op	ne, date and pointion, death	place, and occurred a	due to the car it the time, da	use(s) and ma te and place,	nner as sta and due to	ited. the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier				29c. License				d. Date signe		
)	0			>			Kes	5000	00		5/25		
6			30. Name and address of person who of	1 2	eath (Item 23	а) (Туре,	Print)	י חת	1/0 1	2-11	10000	ΔM 1	0 2/237
	Sta	te	31. Date filed (Month, Day, Year)		ar s Signature			V11	VI L	2-111	141016	7 11	V 0-12-5/
	Registr		MAY 3 1 2	005 Alexander	a K	A	ente						
DH	VIH 17 Rev 1/2	201		Sept Tree of the second		1							

05-3263 UNKNOWN B.K.S FRANK MURRAY

/Medical

Funeral

Director

28a-f show

r than "natural", or Itams 23a or 28a-f shov the Medical Examiner must be nutified at

other

2 should be f and Mental H

ss 1 and 2 sh of Health and Item 27 is m

permit. Pages 1
Department of H
Important: If Ite
any injury or ott

Physician

Examiner

/Medical

the attending physician and ned for use as the buriat-transi

detached

pe

page 2

signed by

Deen

certificate be

P.O.

once.

Maryland 21215-0036

Baltimore,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. unpend item#23a, PIT 27, 28a-f, perMF C843, 6/1/05 TT State of Maryland / Department of Health and Mental Hygiene | | | | |

1- State Registrar AMEND ITEM #1 PER ME G843 5 / Partification of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10, Day 2005 ear MAY **Physician** Frnak Murray FRANK 1927 Рм MURRAY 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE REAR OF 301 POPLAR AVENUE ROSEDALE 6. Sex 1 2 M 2 ☐ F 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 4-19-50 7. Age (In yrs. last birthday) Days Hours 216-50-1772 Yrs. 55 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 No 2 No Director MD Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 2109 E. Monument St. 21224 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Ž☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No SpecifyBlack þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Handyman Yard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Murray Sr. Josephine Clowney George Murray Jr. (brother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 422 Kenwood Ave. Balto. MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X remation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory \$5-18-05 Dundalk, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wesley Chavis Jr. F.H. 2007 Eastern Ave. Balto. MD 21231 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Drowning Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physiclan/Medlcal IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal dea
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertensive cardiovascular disease 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No 24a. Was an autopsy performed? Yes 2□No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 2 No Other: 4 Nursing Home 5 Residence Other (Specify) AT SCENE 1 XYes 27. Manner of Death 28b. Time of **nk** 28d. Describe how injury occurred unk ate of Injury Year) 28c. Injury at Work? Certification: 5 Pending 1 Natural 1 ☐ Yes 2 XNo investigation 5/10/05 М 2 Accident 6X Could not be determined 3 Suicide 28f. Location (Street and Number of Rural Route Number, City or Town, State) **301 Poplar Ave** 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide found in water rear Whitemarsh MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month, Day, Year) 29b. Signapure and title of certifier 29c. License number **OCME** MAY 11, 2005 address of person who completed cause of death (Item 23a) (Type, Print)

Division of Vital Records, After death. within 24 hours after death To the Funeral Director: filled in by the

> State Registrar

ON 31. Date filed (Month, Day, Year) MAY 3 1 2005

Locke

111 Penn Street 32. Registrar's Signature

Baltimore, Maryland 21201

			For State Registrer	State of Maryland		partment of He Pertificate of D			giene 0	05	18069
ı	Physicia	an	1. Decedent's Name (First, Middle, Last))				2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medic		Iris Murphy					_5_	12	200	-
	Examin	er	4a. Facility Name (If not institution, give		-L	4b. City, Town, or	MORE		4c. Cou	nty of Death	1
	Funeral		5. Social Security Number 6. Sec	x 7. Age (In yrs. las			if Under 24 Hrs.	8. Date of Birth) Vocal	9. Birth	nplace (State or Foreign
	Director		210-00-3210	M 20 X F 5	O Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 6-15-	54	MD	intry)
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or L	Location					10d. Inside City Limits
	Mary a-f sh	tor	MD	Bal	timo	ore					X Yes 2 □ No
	or 284	Director	10e. Street and Number			10f. Zip Code			l0g. Citizen o	of What Cou	untry?
	s 23s	rail	4428 Marble Hal			21218	0.1-1.0.10		USA		in a la dia
036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than *natural; or Itams 23a or 28a-f show event, Ita Medical Examitation that in willied at	by Funerai	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates:	13.	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? (Spe n, Mexican, Puerto I Specify:	cry Yes or No- Rican, etc.)	Spe	Black, White cify.Bla	
21215-0036	ithin 72 ho na. nan *natur nan *natur	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Giv life.	edent's Usual Occupa re kind of work done d DO NOT use retired)	uring most of workir		16b. Kind of		ndustry
2	filed w Hygier other th		11th 17. Father's Name (First, Middle, Last)		Home	Care Nu	18. Mother's Name		<u>Priva</u> Maiden Sum		
aŭ	ould be 1 Menta! I arked o	To Be	Fred Murphy				Louise			amoy	
Maryland	2 should be and Mental is marked aumatic ev	⊢	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mai	iling Address (Street a				vn, State, Z	ip Code)
Σ,	and 2 ealth m 27 I		Deanna Rogers (1			Forest			D 212		
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or othar traumatic es		20a. Method of Disposition 1 Nurial 2 Cremation 3 P	TOTIO VALITOTI STATE		oosition (Name of ematory or other place	1		20c. Locatio		
	artmer ortent injury		'4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licens			Heart 22. Name and Addres			Dunda		
Ba	Dep Imp		Musley (ravk		2007 East					
			23a. Part1. Enter the dispase, or compl shock, or heart fature. List only or	ications that caused the death, ne cause on each line.	Do not er	nter the mode of dying	, such as cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
	Physician /Medical	8 1	Immediate Cause (Final disease or condition resulting in death)	SEP:							Offiser and Death
F	Examiner		ſ	Due to (or as a conseque		NITIS					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque		01110					
	acutad and transi	Examiner	that initiated events resulting in death) Last	c							
60,	licata be exacutad physician and s the burial-transit		rosawing in additify Eddi	Due to (or as a conseque	nce or):						
68760,	ificata g phys as the	edicai		d							
P.O. Box	The law requires that the death certificata be exacutad to has been signad by the attending physician and bage 2 should ba detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3	☐Ectopic pregnancy ☐ Other (specify)				Date of delin	very Day Year
S, D	ss Ihat gnad b	by PI	Part II. Other significant conditions con	-	_		n in Part I.				the cause of death?
ord	w require been sig should t	ted	END STAG	E RENAL	DIS	CASC.		1 🗆 Y	es 2 No	3 Pro	bably 4 Unknown
Division of Vital Records,		Completed						24a. Was a autops perform	med?	b. Were aut prior to co death? 1 Yes	opsy findings available ompletion of cause of
Vita	Attending Physicien: r daath. ector: Atter this certifics by the funeral diractor, I	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	dospital:	2/0 11	ent 3□ DOA Othe	26. Place of Death				~ .
0	g Phy er this	E.	27. Manner of Death	28a. Date of Injury 2	8b. Time	of 28c. Injury	4 Nulsing Hote	ne 5 Hesia 18d. Describe h			ity)
Sion	ending sath. or: Aft he fun	atio	1 Aatural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		es 2□No				
<u>X</u>	or Al	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, s	street, factory, office	2	28f. Location (Si City or Town	treet and Nui n, State)	mber or Rui	ral Route Number,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical Co	29a. Certifier (Check only one)	sician: To the best of my knowle ner: On the basis of examinatio and manner stated.	edge, dea n and/or i	ath occurred at the tim investigation, in my op	e, date and place, a inion, death occurre	and due to the c ad at the time, d	ause(s) and late and plac	manner as e, and due	stated. to the cause(s)
	To ti To ti com	Σ	29b. Signature and title of certifier	A		29c. License		2	9d. Date sign		
	_		Nchawta	M.D			-000		5 -	12-1	2005
			30. Name and address of person who co	ompleted cause of death (Item 2 A , $GOOD$ SAN	3a) (Type 1A Ri	TAN HOS	PITAL LO	OCH RAI	IEN R	DULE	VARD 21239
	Sta Registr	32.5	NEENA CHAWA 31. Date filed (Month, Day, Year) MAY 3 1 20	05 32/Registrar's Signatur	e A	parke)				,
	ricgisti	ш	1984 6 8		1						

State of Maryland / Department of Health and Mental Hygiene 1 - For State State Certificate of Death Reg. No.									71115	18070		
			1. Decedent's Name (First, Middle, Last)						Date of Death	Davi Vana	3. Time of Death	
	Physicia		Adela Mirand	la					Month May 25,	Day Year 2005	12:30 %	
	/Medic Examin		4a. Facility Name (If not institution, give st	treet and number)		4b. City, Town, o	or Location of			4c. County of Dea		
	_ Admi	•	3322 Universit	y Blvd., East		Hyatts	sville	3		Prince G	eorges	
	Funeral Director		5. Social Security Number $218-23-7254$ 6. Sex	7. Age (In yrs. las.		If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Min.	Date of Birth Month, Day Aug • 20	^(ear) 1915 E	rthplace (State or Foreign country) OIIVia	
	D		Usual Residence of Decedent								T	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If item 27 Is marked other than "neturel; or items 23a or 28a-f show any injury or other treumetic event, the Marylad Examiner must be maillied a page.	_	10a. State 10b. County Prince	10c. City, 1							10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
		cto		Georges ny	attsv						41	
		Funeral Director	3322 University B1	.vd., East		10f. Zip Code 20783	3		109	g. Citizen of What C United S		
	dea	ner	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of I	lispanic Ori	igin? (Specify	y Yes or No- an, etc.)	14. Race - Am Black, Wh		
98	or its	y Fu	1 Never Married 2 Married	1 □ Yes 2 ▼No If Yes, Give		□¥es 2□No				Specify:		
8	urel',	d by	3 Widowed 4 Divorced	Year or Dates:				ROTI	ivia	01 16 1 1 6 2 1 1	white	
<u>ν</u>	"net	To Be Completed	15. Decedent's Educ (Specify only highest grade		(Give	lent's Usual Occup kind of work done DO NOT use retire	during mos	st of working	16	6b. Kind of Busines	s/industry	
12	within ne. than		Elementary/Secondary (0-12)	College (1-4or 5+)		memaker	0)			own h	OMA	
2	liled v lygie ther t		12 17. Father's Name (First, Middle, Last)				18. Mothe	er's Name (F	irst, Middle, Ma	aiden Sumame)	ome	
Maryland 21215-0036	uld be f Aental H rked of tic eve		unavailable	_				ınavail			·	
lar)	2 sho and 1 Is ma eume		19a. Informant's Name/Relationship (Typ	oe, Print)						City or Town, State,		
Σ	and alth		Gabriel Martinez/				sity E			ville, MD		
ore	of Hi of Hi fiter		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	cem	e of Dispo: letery, cren	sition (Name of natory or other pla	(ce)	Date		Oc. Location - City o		
Ĕ	Pag ment ant: I ury o		`4 □Donation 5 □ Other (Specify)		apeak	e Cremat	ory	5/2//	/2005	Beltsvill	e, MD	
Baltimore,	permit. Departn Importe any inju		21. Signature of Funeral Service License	mann						Services		
			23a, Part1. Enter the disease, or complic	cations that caused the death.	Do not ente	er the mode of dyi	AVENU	ie Silly cardiac or re	ver Sprages	ing, MD	20910 Approximate	
	death certificate be executed //Medical Example at the burial-transit d for use as the burial-transit		shock, or heart failure. List only one cause on each line.							Onset and Death		
•			disease or condition resulting in death)	Due to (or as a conseque	AW CARCLWOMA						6 MONTHS	
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):									
Ć.		Examiner										
8760,		dical	d									
9	tifica ig ph as th	lan/Med								T		
Box	leath certific attending p		IF FEMALE: 23b. Was decedent pregnant 23		□Ectopic pregnancy				23d. Date of delivery			
	ne deat the att hed for	100	in the past 12 months? 1 ☐ Ves 2 ☑ No							Month	Month Day Year	
P.0	⇒ > ○	Physic	9 🗍 Unknown	3CI OTIKIOWII				-				
	Physicien: The law requires this certificate has been signi ral director, page 2 should be	Completed by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					l.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※Unknown			
Vital Records,												
ec									24a. Was an autopsy	prior to	autopsy findings available completion of cause of	
<u> </u>									perform 1 ☐ Yes 2	ed? death? ☑No 1 ☐ Ye	s 2 No	
/ita		Be	25. Was case referred to medical examiner?					e of Death (C	Check only one)		
of V		ပ္	1 (1) Yes 2 (1) No		NOutpatien	I 3 DOM			5 Plesiden		ecify)	
		on:	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Injury 2. (Month, Day Year)	8b. Time of Injury	Work?			1. Describe hov	how injury occurred		
Sio	Attending r death. ector: After by the fune	ertification;	2 Accident investigation				Yes 2					
Division	of Attendation of Attendation of Structor: A din by the f	Ħ	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office		28f	City or Town,		Rural Route Number,	
	itel cris af	O										
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certiffier (Check only one) 29a. Certiffier (Check one									
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licen	se number		29	d. Date signed (Mor	nth, Day, Year)	
	<u> </u>		1 Willow Honor	Sm		D233	308		1	MM 26,0	2005-	
4	4		30. Name and address of person who con	mpleted cause of death (Item 2	3a) (Type,	Print)	nn ·	# UIN	O RFT	THECAL	110 20121-	
7	Sta	ate	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MM 26, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VICTOR M- POLEGO, MD 6420 ROCKUGOGE DR. #4100 BETTES DA, MD 2087 31. Date filed (Month, Day, Year) MAY 3 1 2005 32. Restrar's Signature & Journal of the Control of the									
	Regist	rar	MHISTS	1000								

				State of Marv				-	_		
		•	1 - State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No:						ZIIII	18071	
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last) UII'S @ Mack	۷				2. Date of Death Month MW 2	Day Year	3. Time of Death	
de	Examin		4a. Facility Name (If not institution, give	1 1	and A to	4b. City, Town,	or Location of Death	, /	4c. County of Death	1	
	Funeral		University of Mar. 5. Social Security Number 6. Sec.	7. Age (In	yrs. last birthday)	If Under 1 Year		8. Date of Birth (Month, Day, Ye	9. Birth	nplace (State or Foreign intry)	
	Funeral Director		213-32-5428 15 Usual Residence of Decedent	M 2□F	Yrs.	Months Days	Hours Min.	APR. 30, 1	437 Con	MD	
Maryland 21215-0036	irylanc show	_	10a. State 10b. County 10c. City, Town or Location							10d. Inside City Limits 1 XYes 2 ☐ No	
	the Ma 28a-1 s	Funeral Director	10e. Street and Number 10f. Zip Code					10a	10g. Citizen of What Country?		
	3a or	I Dir	1510 Moster S	3T	7 21217				U.S.A.	,	
	r death	inera	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Origin? (Spe pan, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White		
	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 is marked other than "natural", or Items 23s or 28a-f show traumetic avent, the Medical Evaluter from the retilled at	by Fu	1 ∰ Never Married 2 □ Married 1 □ Yes 2 ★ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:			1□Yes 2 No	Specify:		Specify: Black		
	72 hou natura icul E		15. Decedent's Edu (Specify only highest grad	cation	16a. Dece	dent's Usual Occu	pation during most of working	16b	. Kind of Business/I		
	within 7 ene. than "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	ad)		STEEL		
d 2	filed with Hygiene. other than		17. Father's Name (First, Middle, Last)		, , , , , , , , , , , , , , , , , , ,	- 4 DOR		(First, Middle, Maid			
ılan	Mental Mental arked c	To Be	Joseph Timmon	NS MILLIE				TIMMONS			
lary	2 should and Men is marke	ľ	19a. Inform t's Name/Relationship (T)				t and Number or Rura		-		
	1 an Heall em 2 ther		Kicky Cross - S 20a. Method of Disposition		Ob. Place of Dispo	osition (Name of		Date 200	Location - City or	601 AFT 1502 Fown, State	
nor	of a se		tip Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	MT. CAR	matory or other pl		.05 B	Alto. M	D	
Baltimore,	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service Licens								
Ä	P P P P P		Michael zeg	her			ess of Facility Lighter Fun 17338 BA		1215	Annovimoto	
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, of coopshock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.			4	or respiratory arrest,		Approximate Interval Between Onset and Death	
			disease or condition resulting in death)	a. Metastatic lung Carcer Due to (or as a consequence of): Brain Metastasis							
		L	Sequentially list panditions	b. With 7			one month				
V	rted 	niner	Scantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitiated events c.								
o,	le be executed ysician and e burial-transit	Examin	resulting in death) Last	Due to (or as a co	nsequence of):						
8760	2 2 9	d									
89 X	death certificate b attending physic d for use as the b	/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)					23d. Date of dei Month		very	
. Box	The law requires that the death certifica ate has been signed by the attending phage 2 should be detached for use as the	Physician/Medi								Day Year	
P.O.	that the de led by the a detached f	Phys	9 Unknown					23e. Did tobacco use contribute to the cause of death?			
Records,	uires tha signed id be del	d by	Part in Other significant conditions contributing to death out not resouring in the underlying cause given in 1 acts.						1 ☐ Yes 2 ☐ No 3 D Probably 4 ☐ Unknown		
	tw require s been si	olete									
l Re	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director. After this certificate has be completely filled in by the funeral director, page 2 s	Completed				autopsy performed? 1 ☐ Yes 2 ☑ No autopsy performed? 1 ☐ Yes 2 ☑ No					
of Vital		Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)							
		2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5						Residence 6 Other (Specify)		
ion		atlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury Work?							
Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined							ral Route Number,	
										stated. to the cause(s)	
	thin 24 the F the F mplete	Medical	one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mon								
	N N N N N N N N N N N N N N N N N N N		► MMM	OM C		MI	4452		May 27	2005	
	\wedge		30. Name and address of person wh		ı (Item 23a) (Type	, Print)	445Z Greene St	4 0	11	0.00	
	8		MCUSSA Www. 31. Date filed (Month, Day, Year)	32, Bagistrar's	Signature 22	South (TVREKE ST	vect be	uto, MI	21201	
	Sta Regist	ate rar	MAY 3 1 201		Signature	eg.					

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 26, 2:15 A MAY 2005 LOUISE MYERBERG /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE 14 SPRING FOREST COURT OWINGS MILLS If Under 1 Year If Under 24 Hrs. Min. B. Date of Birth (Month, Day, Year) AUG. 30, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 75 Yrs MD Director 216-52-6454 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show rai', or itame 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 🔀 No OWINGS MILLS BALTIMORE Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21117 USA 14 SPRING FOREST COURT Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Peges 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 🎇 No WHITE Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) The Mis marked other than Elementary/Secondary (0-12) College (1-4or 5+) INTERIOR DESIGN MODEL HOMES 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be SCHWARTZMAN BELLE NAVIASKY HENRY P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14 SPRING FOREST COURT - OWINGS MILLS, MD 21117 ALVIN J. MYERBERG / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Peges
Depertment of
important: if it
any injury or o 1 Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW CEM. 05/27/2005 REISTERSTOWN, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part Letter the disease, or complete the state caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cluse on each line. eus Approximate Interval Between Onset and Death Immedi te Cause (Finaf disease or condition Non-Sme week **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last the attending physicien and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?
1 Yes 2 No
9 Unknown 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 1 Yes 2 No 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Medical Certification: To 28b. Time of Injury Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending 1 ☐ Yes 2 ☐ No death. s after death. investigation 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of fniury - At home, farm, street, factory, office building, etc. (Specify) in by t To the Hospitel within 24 hours a To the Funeral C filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 20061040 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopking Hosp 2din MD harles 31. Date filed month Day, 20075 32. Registrar's Signature State Grade Registrar

ORIGINAL

			1 - For State Registrar	State	of Maryla	and / Depa <i>Ce</i>		nt of H			fental I		ene 0 (15	180	73
			Decedent's Name (First, Middle	e, Last)							2. Date o	f Death			3. Time of	Death
	Physicia		Aubrey Lamar	Nelson							Month May		2005	Year	2:20	АМ
	/Medic Examin		4a. Facility Name (If not institution		ımber)		4b. Cit	y, Town, or	r Location	of Death	1145		4c. County	of Death		
	⊏xamın	ier	Hospice of Che		,									Arun	do 1	
_			5. Social Security Number	6. Sex	7. Age (In vi	rs. last birthday)		napo. ler 1 Year		24 Hrs.	8. Date of	f Birth				or Foreign
	Funeral Director		578-12-0045	1 ∑ M 2□F	91	Yrs.	Month	s Days	Hours	Min.	(Month	, Day, Y	(ear) 1914		lace (State o	
			Usual Residence of Decedent		71				1		Jan.	23,	1914	FIO	rida	
land	A H		10a. State 10b. County		10c.	City, Town or Lo	ocation							1	0d. Inside Ci	ity Limits
Aary	E 2	5	Florida Putna		Ps	alatka									1 🔀 Yes	2 □ No
the	28e-	ect	10e. Street and Number	1111		Tacka	10f 7	Zip Code				100	g. Citizen of \	What Cour	ntry?	
with	ŏ À	ā											J.S.A.			
aath	s 23	Funeral Director	2020 Carr Stree		cedent Ever in	11.0 112		32177	lianania Or	ining (Co.	acity Vac a			e - Americ	on Indian	
e d	me T	nu	11. Marital Status			/8/42	If Yes, sp	pecify Cuba	an, Mexica	n, Puerto	ecity Yes o Rican, etc.)		ck, White,		
s aft	io ii	by F	1 ☐ Never Married 2 ☐ Mar 3 🛣 Widowed 4 ☐ Divorced	If Yes, G	forces? 2 □ No 1 / live Dates: 12 /	/1 //5	1 🗆 Yes	21X No	Specify:	:			Specify			
hours	e a			rearon	Dates: 12/	1/43		1 0	-41			1 46	The Mind of D		<u>ite</u>	
2 2	is a	Completed	(Specify only highe	t's Education st grade completed)	(Give	kind of v	sual Occup vork done o use retired	durina mos	st of work	ing	16	b. Kind of B	usiness/in	dustry	
Į į	han Pan	E	Elementary/Secondary (0-12)	College	(1-4or 5+)				,	2 _ 7 2			T 0 0		_	
ğ V	lygie her t			(Commun	ııcaı	lons					J.S. G		ment	
/land	d of	Be	17. Father's Name (First, Middle,	•									uden Suman	10)		
	Men arke	ို	Cary Wilson No								larre1					
Mar d2sh	and Is m eum		19a. Informant's Name/Relations		- \		-						City or Town,			
6, 18 1 and	ealth n 27 ier tr		Thomas Aubrey	Nelson (S					oad, E			-	yland			
ore	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28e-f show any injury or other treumstic event, I've Medical Evaminer must be retified at once.		20a. Method of Disposition 1	3 DRemoval from		o. Place of Dispo cemetery, cre-	osition (N matory o	lame of r other plac	:е)		Date	20	c. Location -	City or To	wn, State	
ATTIMO	nent int: I		' 4 □ Donation 5 □ Other (5			k Hill	East	Ceme	eterv	5/14	/05	P	alatka	a, FL		
	partn ports / inju		21. Signa ure of Funeral Service	Licensee		2:	2. Name	and Addres	ss of Facili	ity						
n ä	Depar Impo any ir		Domnia.	Fillm	enn	5	Mast 3015	ers I	uner 11 Av	aı но	ome Palati	ka.	FL 321	177		
			23a. Part1. Enter the disease, o shock, or heart failure. List	complications that	ceused the de	eath. Do not en									Approximat Interval Bet	0
Di			Immediate Cause (Final	only one cause on	Canil L	22.01	101	neen	001410	,					Onset and I	
	nysician Medical		disease or condition resulting in death)	a. Duo to	(or as a cons	exory		حدرر	CVITC	1						
E:	xaminer				(01 43 4 00113	oquence yi).										
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to	(or as a cons	sequence of):										
ted	nsit	n in	cause. Enter Underlying Cause (Disease or injury	<												
xecu	and al-tra	Examin	that initiated events resulting in death) Last	C. Due to	(or as a cons	sequence of):										
of ou, cate be executed	physician and the burial-transit	aiE														
cate	phys the	dicai		d												
DX C	ding se as	/Me	IF FEMALE:	23c If yes or	utcome of pre	nancy							22d Day	to of dolbro		
ath C	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2 F	etal death 3[pregnancy	,				1.	te of delive Inth		rear
. e	the hed	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unk	inant at time o nown	nueam st	Other (specпy)				_				
The law requires that the death certifi	certificate has been signed by the attending I rector, page 2 should be detached for use as		Part II. Other significant conditi	one contributing to	death but not i	reculting in the u	inderhind	cause civ	on in Part	1	23a [Did toba	cco use cont	ribute to th	ne cause of d	leath?
5 18	signe be d	Ď	The Confession of			resulting at the c	in to or ty in s	g cause giv	Oit iii i ait i	1.			2 □ No	3 ☐ Prob		Jnknown
inber redui	een s	ted	Deceration	ACC II	200						-		2 110	0	abi, 1/2	
RECOLUS he law requires	as b	ple	- Deulia								a	Mas an utopsy		prior to co	psy findings and pletion of co	available ause of
r e	ate h page	Completed									1 🗆 Y	erforme es 2,2	id? Li No	death? 1 ∐ Yes	2□ No	
VICAL ician: 1	rtific stor,	Be (25. Was case referred to medical examiner?	il .					26. Place	e of Deatl	h (Check o	nly one)				
(5)	is ce	10	1 ☐ Yes 2 No	Hospital: 1	Inpatient 2	. ☐ ER/Outpatie	nt 3 🗆 [DOA Oth	er: 4 □ Ni	ursing Ho	me 5 🗆 F	Residen	ce 6 Oth	er (Specify	1) ASS-	100
P Phy	ter th		27. Manner of Death	28a. Date	of Injury nth, Day Year	28b. Time o	of	28c. Injun Wor	y at		28d. Descr	ibe how	injury occur	red		
SION	r: Af e fur	atic	1 Natural 5 Pendi 2 Accident invest	19		,,,	М		Yes 2 🗆	No No						
VIS Afte	ecto ecto by th	iji	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 280. Place	e of Injury - A	t home, farm, st	reet, facto	ory, office			28f. Locatio	on (Stre	et and Numb	er or Rura	I Route Num	ber,
5 🔓	s afte	Certification;	4 Carlomoide	Dail	ung, etc. (Spe	city)					Only of	101111,	olulo,			
spite	within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier Certifyi	ng Physicien: To th	e best of my l	knowledge, deat	h occurre	ed at the tin	ne, date ar	nd place,	and due to	the cau	se(s) and ma	anner as si	ated.	
e H	n 24 l	edical	(Check only 2 Medicel	Examiner: On the and ma	basis of exam nner stated.	ination and/or in	vestigati	on, in my o	pinion, dea	ath occur	red at the ti	me, date	e and place,	and due to	the cause(s)
o th	vithir To th comp	¥	29b. Signature and title of certifie	er Z		,	2	9c. Licens	e number			290	. Date signe	d (Month,	Day, Year)	
_	-		A	VITTIA.	\mathcal{C}	MOPRA		15	02	8			5/12/	7-		
.7	•		30. Name and address of person	who completed car		ν		N)		3			1-1	-)		
10	/		A 7:.	600 D#		Ave., A		olic	Mars	v1and	1		1			
	Sta	l ato	31. Date filed (Month, Day, Year MAY 3 1 2	32.		eature of				,						
	Registr		MAY 3 1 2	2005	was s	1 Jane	-									

		-	For State Registrar	State of Maryland		ent of Health ate of Death			giene Reg. No.	005	18074
	Physicia	_	1. Decedent's Name (First, Middle, Last) CYNTHIA OCK (ME	-V				2. Date of Dea	Day	Year	3. Time of Death
7	/Medic Examin	al .	4a. Facility Name (If not institution, give s	treet and number)		ity, Town, or Location		05	4c. Co	2005 ounty of Deat	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. Ja		der 1 Year If Unde	r 24 Hrs.	8. Date of Birt Month, Da	y Year) 19	9. Bin	hplace (State or Foreign Intry)
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County NA	10c. City,	Town or Location	altimore					10d. Inside City Limits 1 Yes 2 No
	h with the 23a or 28a	Funeral Director	100. Street and Number 609 N. Chapel	gate Lane A	pt. 202 10t.	Zip Code 2122	29		10g. Citize	n of What Co	ounter?
036	be filed within 72 hours after death with the Maryland Ital Hygiene. od other than "natural", or Items 23s or 28s-f show event, Its Medical Evaninal must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Z. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Yes,	cedent of Hispanic O specify Cuban, Mexica s 2 No Specify	an, Puerto F	cify Yes or No Rican, etc.)		. Race - Ame Black, White pecify: Black	
21215-0036	d within 72 ho giene. Ir than "natur It e Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. Decedent's U (Give kind of life. DO NO Admin's	Isual Occupation work done during mo T use retired)	ASSI	start	Toh.	of Business/	ndustry Kins Hospital
Maryland	ould be fited Mental Hygi arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last) Johnnie L. Bar	res, Sr.		01	a K.	(First, Middle,	25		11220
	i and 2 should fealth and Mer im 27 is marke her traumatic		19a. Informant's Name/Relationship (Ty) Nillan Bark 20a. Method of Disposition	-husband	19b. Mailing Addr	ress (Street and Number Chaple	lgate	Route Number	20c. Loca	Sattin	ore Maryland Town State
Baltimore	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other once.		1 Burial 2 Commation 3 R 4 Donation 5 Other (Specify) 21. Signature of Junear Service	100	metery, crematory	or other place) May 0 e and Addres Faci	5/2	7/05 Ch Fu	Cate	neville	e Maryland
ä	Depa Impo any ii		23a. Part1. Enter the disease, or compfi	cations that caused the death.	35 / 2 Do not enter the r	Tredex mode of dying, such a	s cardiac o	-Arc r respiratory a	Bat rrest,	timor	Approximate Interval Between
	Physician /Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)			2 DISEASE					Onset and Death Byears
5	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	ence of):						Jgcc 13
,092	te be executed ysician and te burial-transit	cai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	ence of):						-
99	a × a		IF FEMALE:								
O. Box	The law requires that the death certifica the has been signed by the attending phoage 2 should be detached for use as it	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 ☐ Ectop	ic pregnancy r (specify)			23	d. Date of de Month	liv <i>e</i> ry Day Year
rds, P.0	juires that the de n signed by the a ud be detached f	by	Part II. Other significant conditions con	ntributing to death but not resu	lting in the underlyi	ng cause given in Par	t I.	23e. Did t			o the cause of death?
I Records,	10	Completed								24b. Were at prior to death?	utopsy findings available completion of cause of
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	lospital:	-D/O	Other	ice of Death	(Check only o	_	□Other (Spe	noihe)
of		 -	1 Yes 2 No	T	ER/Outpatient 3 28b. Time of Injury	28c. Injury at Work?		28d. Describe			icity)
Division	or Attending ter death. irector: Afte n by the fune	Certification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hos building, etc. (Specify	M me, farm, street, fa	1 ☐ Yes 2 [ctory, office		28f. Location (City or To		Number or R	ural Route Number,
٥	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Ce	29a. Certifying Phy (Check only one)	sician: To the best of my know ner: On the basis of examinat and manner stated.	wledge, death occu ion and/or investiga	rred at the time, date attion, in my opinion, d	and place, a	and due to the ed at the time,	cause(s) a date and p	nd manner a	s stated. e to the cause(s)
	To the within ;	Mec	29b. Signature and title of certifier			29c. License numbe			29d. Date	1 - 1	th, Day, Year)
	5) Junter			P176	168		5	27/09	5
,	1		30. Name and address of person who co	SOUTH GIVEENES	MEET B	ALTIMONE	MD 7	2001			
	St Regist	ate rar	31. Date filed (Month, Day, Year) MAY 3 1 2	32. Registrar's Signat	of Spare	W					

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of I	Marylan	-		of H	ealth a		_		005	180	75
			Decedent's Name (First, Middle	a, Last)							2. Date of De	ath		3. Time of	Death
	Physic	an	CHARLES	WEBSTE	R	20	PE				Month	Z7	200 S		PM
	/Medic		4a. Facility Name (If not institution				4b. City, To	OWD OF	Location	of Death	/////	-	County of Dea		
	Examin	er							PLLSTO	,)		ALTIN		
			NORTH WEST 5. Social Security Number	HOSPITAL		last birthday)									or Formian
	Funeral		241-14-2732	6. Sex- 7.	83	Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Da 8-9-19	y, Year)	9. Bi	rthplace (State of country) NC	or roreign
	Director		Usual Residence of Decedent				J				0-9-19			110	
	and		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation				×			10d. Inside C	ity Limits
	Aary I sho	ō	MD Anne	Arundel	G1	en Bur	nie							1 ☐ Yes	2 X No
	the l	ect	10e. Street and Number				10f. Zip C	20d0				10a Citis	en of What C	auntai?	
	with	₫	318 Wilson Blv	d				2106	1			rog. Onia	USA	ountry:	
	within 72 hours after death with the Maryland ene. then "naturel", or items 23a or 28e-f show the Medical Exament must be notified at	by Funeral Director		12. Was Decede	nt Ever in II	C 12				ain? (Cna	oit. Vac or No	1	4. Race - Am	oriogo Indian	
	item item	E S	11. Marital Status	Anned Force	es?	.5.	If Yes, specif	y Cubar	n, Mexican	gin / (Spe i, Puerto	cify Yes or No Rican, etc.)	'	Black, Whi		
36	', or	Ž	1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	ied 1 [2]Yes 2 If Yes, Give Year or Date			1 ☐ Yes 2	No E	Specify:				Specify:	white	
Ş	hour turei	b	15. Deceden			16a Doon	dent's Usual	Occupa	tion			16h Kir	nd of Business	-/Industry	
5	"na"	Completed	(Specify only highes			(Give	kind of work DO NDT use	done d	uring most	t of worki	ng	100, Kii	id of Business	windustry	
12	withi	Ę	Elementary/Secondary (0-12)	College (1-4	or 5+)		Pipe F					Beth	ılehem	Stee1	
2	illed Hygi ther nt,		17. Father's Name (First, Middle,	Last)		1	P-			r's Name	(First, Middle,	Maiden :	Sumame)		
ano	ntal l	Be	Jay W. Pope								Causey				
3	Men Mark Mark	2		his Cons. Oriet		40h 14-111		(011-				0.4	T C1-1-	7:- 0- 4-1	
Maryland 21215-0036	12 st h and 7 is n treun		19a. Informant's Name/Relations Mr. Thomas Shie		on						Route Number Burnie,			ZIP CODB)	
a)	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then. Insturei; or items 23a or 28e-f show appring to other treumatic event, the Medical Exament must be published at ance.										ate		cation - City or	r Town State	
Baltimore,	Fof H		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from Sta	ate 200. F	Place of Dispo cemetery, cre	matory or oth	ner place	9)						
Ē	men men ent:		' 4 □ Donation '5 □ Other (S	pecify)	Mea	adowrio	_						ridge,		
ä	permit Depart Import any in		21. Signature of Funeral Service	Licedsee	340.1		2. Name and				ngleto:	ı Fur	neral H	lome P.A	
ш_	6 5 E 6 0		Mula	Un-	M01	364 1	Secon	A D	ve SW	, G1	en Burr	nie M	D 2106	1	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau only one cause on eac	sed the deat h line.	h. Do not en	ter the mode	of dying	, such as	cardiac o	r respirato <i>r</i> y a	rrest,		Approximat Interval Bet	ween
1	Pnysician	0.1	Immediate Cause (Final disease or condition	AC	UTE	MYDC	ARDIA	14	INI	FAR	CTIUL)		Onset and	Death
	/Medical		resulting in death)		as a conseq		711	_						1	
н	Examiner			b											
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		as a conseq	uence of):									
	d d ansii	Examiner	Cause (Disease or injury that initiated events	С.											
o,	exection and and rial-tr		resulting in death) Last		as a conseq	uence of):									
68760,	death certificate be executed e attending physicien and id for use as the burial-transit	cai		d											
68	leath certifical attending phy I for use as th														
Вох	n cert andin use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			76	22.1.1				2	3d. Date of de	elivery	
	death e atte d for	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnan	n 2 □ Feta tat time of d		⊒Ectopic pred ☐ Other (sped						Month	Day	Year
P.O.	that the de ned by the a detached t	Physician/Med	9 Unknown	9 Unknow	n										
	igned the per per per per per per per per per pe	by P	Part II. Other significant condition	ons contributing to deat	h but not res	ulting in the u	ınderlying cau	use give	n in Part I.		23e. Did t	obacco us	se contribute t	to the cause of c	leath?
ds	requires neen sign hould be										1 🗆 '	Yes 2]No 3□P	robably 4 🖭	Jnknown
00	> 10 0	lete									24a. Was	an	24b. Were a	utopsy findings	available
Records,	The law ate has b page 2 st	Completed										rmed?	prior to death?	completion of c	ause of
त	icien: Ti certificate ector, pa	Ö	25. Was case referred to medical							10		2 1 No	1 🗆 Yes	s 2□No	
of Vital		o Be	examiner?	Hospital:		ED/O		Othe			(Check only o				
of		-	27. Manner of Death	28a. Date of I		ER/Outpaties 28b. Time o		- Aug house	4 🔲 Nu		ne 5 🗌 Resid 28d. Describe I			ecity)	
n	Attending F r death. ector: After by the funera	tion	1 Matural 5 ☐ Pendin	g (Month,	Day Year)	Injury	м	c. Injury Work	? ′es 2 □ l			,,			
S	uttendia death. ctor: A y the fu	ca	3 Suicide 6 □ Could	not be	Injury - At h	ome farm st				-	28f. Location (Street and	Number or F	Rural Route Num	her
Division	7 0 7 0	Certification:	4 Homicide determ	building,	, etc. (Specif	(y)	root, ractory,	011100			City or To				
_	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	ai	29a. Certifier 1 Certifyin	g Physician: To the be	ast of my kno	wiedne dest	h occurred at	t the tim	e date an	d place	and due to the	Cause/e)	and manner a	s stated	
	24 hos Fun etely	dica	(Check only 2 Medical one)	Examiner: On the basi	s of examina	ition and/or in	ivestigation, i	n my op	inion, deal	th occurr	ed at the time,	date and	place, and du	e to the cause(s	;)
	o the	Med	29b. Signature and title of title)//			29c.	License	number			29d. Date	signed (Mon	th, Day, Year)	
1	8 4 8 4			/(//		7.	7	57	722			MAI	1	200	5
•	6		20 News and address of	uho completed cours	155	. D ·				11111111		/* - []	121	200	
1)		30. Name and address of person	ARASON M.C.				T AA	10 20	11000	CTOLL	1A A	7.127	,	
	Sta	to	31. Date filed (Month, Day, Year)	32 🖼			THE STATE OF THE S	1 4	TI / \/	PHU	ISTOWN,	NIL	21133		
	Registr		MAY 3	1 2005	istrar's Signa	10 17									

			1 = For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment <i>tificate</i>				jiene	05	18076	5
			1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month	Dev	Yeer	3. Time of Death	
1	Physici /Medio		HAROLD		POS	SNER			MAY	25,	2005	8:55 A M	-
	Examir	er	4a. Facility Name (If not institution, give s			4b. City, T	Town, or	Location of Death	MILLS	4c. Cour	nty of Death	MODE	
180	· ·	, in	9450 WORDSWORTH 5. Social Security Number 6. Sex		(In yrs. last birthday)	If Under	1 Year	OWINGS If Under 24 Hrs.	MILLS 8. Date of Birth	1	BALTI 9. Birthp	. MUKE lace (State or Foreign itry)	n
	Funeral Director			M 2□ F	78 Yrs.	Months	Days	Hours Min.	8. Date of Birth (Month, Day MAR. 31	1927	Coun	PA	
	D .		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	cation					1	0d. Inside City Limits	_
	the Marylar 28a-f show	ō	MD BALTI	MORE		NGS MI	211					1 ☐ Yes 2 ☑ No	
	28a-	Director	10e. Street and Number	HOILE	0111	10f. Zip			1	l0g. Citizen o	of What Coun	itry?	_
	23a or	a Di	9450 WORDSWORTH	WAY #104				21117			US	SA	
	items in items	ner	T. Maria States	Was Decedent B Armed Forces?		Was Decede	ent of Hi	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes of No- Rican, etc.)	14. R	ace - Americ lack, White,		
36	s afte	by Funeral	1 💢 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ZYes 2 ☐ N If Yes, Give Year or Dates:	10	1 ☐ Yes 2	No K	Specify:		Spec	cify:	WHITE	
5-0036	172 hours after death with the Maryland "natural", or items 23a or 28a-f ahow salical Examiter must be notified at		15. Decedent's Educ	ation		dent's Usual			Ť	16b. Kind of	Business/Inc	dustry	
215	C	Completed	(Specify only highest grade	College (1-4or 5	`life. i	DO NOT us	e retired,						
2121	filed with Hygiene. other ther			+	ADM:	INISTR	RATIO					RITY ADMIN	
and	should be filed withir nd Mental Hygiene. marked other than matic event, Ita M.	Be	17. Father's Name (First, Middle, Last) IRVING		POSI	(FD		18. Mother's Nam MIRIAM	e (FIFST, MIGGIE,	Maiden Sum	ame)	RAWITZ	
Maryland	2 should and Men is marke	ျှ	19a, Informant's Name/Relationship (Type	oe, Print)			(Street a	and Number or Rur	al Route Numbe	r, City or Tox	m, State, Zip		
E S			SHALOM SALFER /		FRIEND 382	22 MEN	ILO I	DRIVE - E	BALTIMOR	E, MD	21215		
Jre,	of Head		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □ R	amoval from State	20b. Place of Dispo cemetery, crei	sition (Nam natory or ot	e of her place		Date	20c. Locatio	n - City or To	wn, State	
Baltimore	Pagiment ment: h		`4 ☐Donation 5 ☐ Other (Specify)		CHEVRA A						LLST0W		_
Ball	permit. Pages 1 and. Department of Health Important: If Item 27 any injury or other tr once.		21. Signature of Funeral Service License	0 -	1				L LEVIN				
<u> </u>			23a. Part Entyr the disease, ir comp show, or heart failure. List of hym	ations that caused	the death. Do not ent	er the mode	CEIS of dying	TERSTOWN g, such as cardiac	Or respiratory are	PIKESV rest,	ILLE,	Approximate	_
	Physician		Immediate Cause (Final	e cause on each lir	18.	<u></u>	0	Rhova	es ilas	7.50	Lass	Interval Between Onset and Death	
	/Medical		diseas or condition resulting in death)	Due to (or as	a consequence of):	7/6	1	KELO V.A.	SCUININ	12/11	IRE	Jeties	
la d	Examiner	L	Sequentially list conditions, b	F1 - 44 F1 - 44									_
	ped lst	nlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):								
~	execut n and al-trar	Examin	that initiated events cresulting in death) Last	Due to (or as	a consequence of):		_				-		
8760,	cate be executed physician and the burial-transit	dical											_
9	certifica nding ph use as th	Medi	IF FEMALE:										
Вох	death ce e attendi	Physiclan/Med	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pre				1	Date of delive Month	Day Year	
0	the de by the a	ysic	1 Yes 2 No	4□Pregnant at 9□ Unknown	time of death 5L	Other (spe	эспу)						
۹.	es that the death certific igned by the attending p be detached for use as	by Ph	Part II. Other significant conditions con	tributing to death b	ut not resulting in the u	nderlying ca	ause give	en in Part I.	23e. Did to	bacco use co	ontribute to th	ne cause of death?	
rds	w requires that been signed b should be deta	ed b							1 □ Y	es 2 No	3 Prob	ably 4 Unknown	١
900	aw Isb	Completed							24a. Was a	an 24	b. Were auto	psy findings available mpletion of cause of	а
ä	The ate h page	Com							perfor 1 ☐ Yes	med? 2 2 No	death? 1 ☐ Yes		
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical example?	ospital:			Othe	26. Place of Deal	/				
of	Phys r this ral di	- T	1 🗹 Yes 2 ☐ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	1 ☐ Inpatie 28a. Date of Inju (Month, Day			8c. Injury Work	4 Nursing Inc	ome 5 nesid			1)	
ion	Attending Ph r death. sctor: After they the funeral	atlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	y Year) Injury	М		<br Yes 2 □ No					
Division of Vital Records,	r Atter	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injuding, etc.	ury - At home, farm, str c. (Specify)	reet, factory	, office		28f. Location (S City or Tow	treet and Nu n, State)	mber or Rura	il Route Number,	
	To the Hospital or Attenwithin 24 hours after deal To the Euneral Director: completely filled in by the	Cer											
	Hosp 24 hou Fune stely fi	edical			of my knowledge, deat f examination and/or in ated.								
	To the within To the comple	Me	29b. Signature and tiple of certifier			29c	. License	e number		29d. Date sig	ned (Month,	Day, Year)	
			641,00	Alma m	Mud	1	911	1111		MAY.	25, 2	-005	
	ĺλ		30. Name and add ess of p rso who a	me ted cause of d	leath (Item 23a) (Type.	Print)	1				CONTRACTOR OF THE PARTY OF THE		
	1		31. Date filed (Month, Day, Year)	30 Paniete	933 STJ ar's Signature	OLNS	LA	NE IET	Licota	(,Ty	ma	1005 21042	
	St	ate	51. Date filed (Moriti, Day, 16a)	J. Hogisti						,		21042	

DHMH 17 Rev 1/2001

ORIGINA

			1 - For State Registrar	State of Mar	-	ertificate of I			iene og. No.	5	18077
	Physici /Medic		1. Decedent's Name (First, Middle, La. Geraldine	Marie		Roberts	6	2. Date of Deat	Day	Year 2005	3. Time of Death
	Examin		4a. Facility Name (If not institution, giv ST. AGNES HOS 5. Social Security Number 6. S	PITAL	(In yrs. last birthday	4b. City, Town, or BAIIMOR	Location of Death 2E, MD. If Under 24 Hrs.	8. Date of Birth	4c. County	9. Birth	place (State or Foreign
	uneral irector			□M 2対F	Yrs.	Months Days	Hours Min.	June 20		Cou	ntry)
e Maryland	te-f show	ctor	10a. State 10b. County Maryland N/A		Baltimore						10d. Inside City Limits 1√1 Yes 2 1 No
ath with th	ust be no	ral Director	10e. Street and Number 3308 Benson Ave.			10f. Zip Code 2122			0g. Citizen of V		
0036 hours after death with the Maryland	other than "natural", or Itams 23a or 28e-f show avant, I'e Medical Exac diret must be redified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2√ No If Yes, Give Year or Dates:	er in U.S.	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ck, White,	can Indian, etc. hite
d 21215-0036 filed within 72 hours af Hydiene.	than "natur	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12	ducation ide completed) College (1-4or 5+)	(Giv life.	edent's Usual Occup e kind of work done o DO NOT use retired	during most of worki	ing	16b. Kind of Bu		dustry s & Electri
be filed		Be	17. Father's Name (First, Middle, Last,			siitei	18. Mother's Name			ne)	_
Maryland d 2 should be file	item 27 is marked other traumatic av	<u>ڳ</u>	John Pau1 19a. Informant's Name/Relationship (edidages 19b. Mai	ling Address (Street	Mildred and Number or Rura	al Route Number,	City or Town,		rby Code)
_ = =	n 27 is ier trau		Paul F. Roberts	(Son)		4 Bayfront			e, MD 2	1219	
Baltimore, permit. Pages 1 at Department of Hea	Importent: If item any injury or othe once.		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specification 2). Signature of Funeral Service Lices	y)	Loudon Pa	position (Name of permatory or other place ark Cemete 22. Name and Address 8620 Wilke	ry 5/25 ss of Facility Lo	5/05 oudon Pa	rk Fune	re, ral	Maryland Home
/M	physician and edical sthe burial-transit	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	consequence of): consequence of):	10 f7 c	Cardia) VO St-	io D	1505	Onset and Death Se yes
O. BOX	by the attending lached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)	,		23d. Dat Mo	te of delive	ery Day Year
ords, P.	been signed b should be deta		Part II. Other significant conditions of	ontributing to death but	not resulting in the	underlying cause give	en in Part I.	23e. Did tob	4.		he cause of death? pably 4 DUnknown
	ate has page 2	Completed						24a. Was ar autops perform 1 \(\text{Yes} \) 2	y ngơi?	Were auto prior to co death? □ Yes	ppsy findings available mpletion of cause of
VItal	this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: ↑ ☐ Inpatient	2 ER/Outpatie	ent 3 DOA Oth	26. Place of Death er: 4 ☐ Nursing Ho	n <i>(Check only one</i> me 5 ☐ Reside		er (Specif	(v)
DIVISION Of VITA To the Hospital or Attending Physician: within 24 hours after death.	vr: After thi	atlon; T	27. Manner of Death 1 Matural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day 1	28b. Time	of 28c. Injun World	y at	28d. Describe ho			,,
DIVIS	al Directo	Certification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, s (Specify)	treet, factory, office		28f. Location (St. City or Town		er or Rura	al Route Number,
he Hospi	To the Funeral Director: After completely filled in by the funera	Medical	29a. Certifier (Check only one) Certifying Physics (Check only one)	ysician: To the best of niner: On the basis of e and manner state	xamination and/or i	ath occurred at the tin nvestigation, in my o	ne, date and place, pinion, death occurr	and due to the ca red at the time, da	use(s) and ma ate and place, a	nner as s and due to	tated. o the cause(s)
Tot	Too Wood	Σ	29b. Signature and title of certifier A:H	endana f	hysicia	29c. Licenson	5/853	3	9d. Date signed		
27)		30. Name address of person who	Ivermos	90	Print)	No Ave	enve	Balti	MOC	, 2005 e 2/229
	Sta Registr	_	31. Date filed (Month, Day, Year) MAY 3 1	32. Redistrar	s Signature	Sparle	7				

Roberts, Geraldine M.

			1 - For State of Maryland / Dep Registrar Ce	artment of Health and M rtificate of Death	Reg.	4000	18078
۱	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Alice W. Reedy 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	May 25,	2005 4c. County of Death	12:00A ^M
	Examin	er	Manor Care	Towson			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Baltimore 9. Birthpl	ace (State or Foreign
Ш	Director		216-14-7405 1 M 2 AF 91 Yrs.	Months Days Hours Min.	(Month, Day, Ye		
	and *	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		•	d. Inside City Limits
	Maryli f aho	ō		· 110			1 □Yes 2√No
	r 28a-	rec	MD Baltimore Luthery 10e. Street and Number	10f. Zip Code	10g.	Citizen of What Count	ry?
	th with	Funeral Director	13 Wendslow Road	21093		USA	
	ems	iner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	
36	s afte	by Ft	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ XNo If Yes, Give 3 ☐ XWidowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: Whi	
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f ahow disal Ezardinar must be indified at	edt	15. Decedent's Education 16a. Dece	edent's Usual Occupation	166	. Kind of Business/Ind	
215	within 72 lene. than "na	plet	(Specify only highest grade completed) (Given Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of worki DO NOT use retired)	ing		
21	e filed within al Hygiene. I other then ' vent, the Me	Completed	4 Hom	emaker		Own Home	
and	ould be fil Mental H arkad oth atic evan	Be	17. Father's Name (First, Middle, Last) Hamilton Boyd Wylie		e (First, Middle, Maio 18al Landr		
Maryland	2 should be and Mental Is markad raumatic ev	ဥ		ing Address (Street and Number or Rura			Code)
≥	1 and 2 s Health ar tam 27 ls			-	a MD 2114		,
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event. The Medical Examinating the confilled at ODGs.	1	20a. Method of Disposition 20b. Place of Disposition cemetery, cre	osition (Name of practice)	Date 20c	Location - City or To	vn, State
Ë	Page ment ant: I			ark Cemetery June	6, 05 Ba	ltimore Ci	у
Salt	permit. Pa Departmen Important: any injury		21. Signature of Funeral Service Licensee	2. Name and Address of Facility ${ m Lo}$	udon Park	Funeral H	ome
	405 40		23a. Party. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	620 Wilkens Ave.	Baltimore	MD 21229	Approximate
8760,	/Medical personned and India physician and India physician and India physician site as the pural-transit	sal Examiner		structive Pulmo			Onset and Death
P.O. Box 68	it the death certif by the attending tached for use as	Physician/Medical		□Ectopic pregnancy □ Other (specify)	22a Did tahan	23d. Date of deliver Month	Day Year
ds,	es ign be	d by	Part II, Other signmeant conditions contributing to death out not resulting in the	underlying cause given in Fart i.	1 Yes		ibly 4 Unknown
Vital Records,	The taw ate has b page 2 s	Completed			24a. Was an autopsy performed	prior to con death?	sy findings available upletion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		(Check only one)		
of	Phys rthis ral dii	- To	1 Tes 2 Inpatient 2 ER/Outpatie	The second secon	me 5 🗌 Residence 28d. Describe how i)
on	Attending Phr r death. actor: After th by the funeral	tlon	27. Manner of Death 1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Year) Injury	Work? M 1 □ Yes 2 □ No		.,,	
Division		Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural tate)	Route Number,
	To tha Hospital or Al within 24 hours after or To tha Funaral Dirac completely filled in by	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal (Check only one) 1 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, ovestigation, in my opinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as sta and place, and due to	ited. the cause(s)
	To tha within 2 To tha complet	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, L	
)	X		Jen yer or so to	1+0054424	5	-25-05	
6			30. Name and address of person who completed cause of death (Item 23a) (Type Cyrus Asadi 20 East Timonium R		nium, MD	21093	
	Sta Registi		31. Date filed (Month, Day, Year) MAY 3 1 2005 32. Prigistrar's Signature	barke			

1- State of Maryland / Department of Health at Certificate of Death	nd Mental Hygiene 0 5 8 0 7 9
Decedent's Name (First, Middle, Last) Physician Decedent's Name (First, Middle, Last)	Date of Death Month Day Year
/Medical Lucy G. Redillond	May 25 2005 2:25a.M
4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of	Death 4c. County of Death Baltimore
Ruxton Manor Care Towson 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2	
Director 220-20-3191	Hrs. B. Dete of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) NC
Usual Residence of Decedent	
10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits %⊡% es 2 □ No
MD NA Baltimore 106. Street and Number 106. Zip Code	10g. Citizen of What Country?
Light total and Nothings	
3246 Sequoia Ave 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Original Hammed Forces? 14. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 16. Was Decedent Ever in U.S. Armed Forces?	U.S.A. n? (Specify Yes or No- 14. Race - American Indian,
Amad Forces? I Never Married 2 Married Amad Forces? If Yes, specify Cuban, Mexican, Next Section 1 Yes 2 Yes 2 No 1 Yes 2 Y	
3 Widowed 4 Divorced Year or Dates:	Specify: Black
10a. State 10b. County 10c. City, Town or Location	of working 16b. Kind of Business/Industry
Elementary/Secondary (0-12) 12th grade 2yrs Elementary/Secondary (0-12) 2yrs Enterprenuer	Salon
S S S S S S S S S S S S S S S S S S S	s Name (First, Middle, Maiden Surname)
e de la companya de l	a Dupree
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	or Rural Route Number, City or Town, State, Zip Code)
Sidney Redmond-Husband 3246 Sequoia Ave	, Baltimore, Md 21215
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
A Burial 2 Cremation 3 Removal from State A Donation 5 Other (Specify) Carrison Forest Vet 21. Signature of uneral Service Licensee A Donation 5 Other (Specify) 22. Name and Address of Facility March, F/H Wes	• 5/31/05 Owings Mills, Md
Sidney Redmond-Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 32b. Place of Disposition (Name of cemetery, crematory or other place) 32b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) 32c. Name and Address of Facility 43c. Name and Address of Facility	tve, Baltimore, Md 21215
Part 1. Enter the disease, or complitations in it caused the death. Do not enter the mode of dying, such as cashed shock, or heart failure.	Interval Between
Physician Immediate Cause (Final disease or condition a	Onset and Death
/Medical resulting in death) Due to (or a / consequence of):	
Sequentially list conditions. b.	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause (Underlying that initiated events resulting in death) Last Due to (or as a consequence of):	
That initiated events c. So a fine in the initiated events c. Due to (or as a consequence of):	
Cases. Enter Underlying Cases. Enter Underlyi	
M le temare:	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify) 9 Unknown	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
s so one of the significant containing to deal out not resulting in the discensiving cause given in Part i.	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
The law requirements of the la	24a. Was an 24b. Were autopsy findings available
O O O O O O O O O O O O O O O O O O O	prior to completion of cause of death? 1 □ Yes L No 1 □ Yes 2 □ No
Report of the second of the se	Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nurs	ing Home 5 Residence 6 Other (Specify)
28a. Date of Injury 28b. Time of 28c. Injury at Work?	28d. Describe how injury occurred
Accident investigation M 1 Yes 2 N	28f. Location (Street and Number or Rural Route Number,
2 3 Suicide 6 Could not be 290 Place of Injury. At home farm class testing	Est. Education (of dat and trambal of flural floate ramber,
1	City or Town, State)
27. Manne Death 1	place, and due to the cause(s) and manner as stated.
3 Suicide 4 Homicide 3 Suicide 4 Homicide 4 Homicide 3 Suicide 4 Homicide 4 H	place, and due to the cause(s) and manner as stated. occurred at the time, date and place, and due to the cause(s)
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and (Check only one) and manner stated. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and and manner stated.	place, and due to the cause(s) and manner as stated. occurred at the time, date and place, and due to the cause(s)
3 Suicide 4 Homicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 4 Homicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier (Check only) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated. 29b. Signature and little of certifier 29c. License number 3 Signature and little of certifier	place, and due to the cause(s) and manner as stated. occurred at the time, date and place, and due to the cause(s)

State of Maryland / Department of Health and Mental Hypigine 1 Season Research Physician / December Name (Physician) / December Name (Phy				Please		nt in Black In			-	•	
Physician Medical Exeminer 4. Facility Name (If not installation, your street and number) 4. Coty Town, or Location of Death 4. Coty Town, or Location of Death 7. Pop (In your set before) 8. Special Security Number (If not installation, your street and number) 4. Coty Town, or Location of Death 7. Pop (In your set before) 8. Special Security Number (If not installation, your street and number) 8. Special Security Number (If not installation, your street and number) 8. Special Security Number (If not installation) 1. Special Secur		•	_ State		State of M					2000	18080
Salomea M. Reardon May 28, 2005 11:45 AM As Facily Name if from insulation of beauty from state and number) Manor Care Ruxton 5. South Salomea M. Reardon May 28, 2005 11:45 AM TOWSON Salomea M. Reardon Baltimore 8. Country of Death Baltimore 212-03-967 Low Participora of Geodeside 1. Subset of Country 1. Subset o			1. Decedent's Name (i	First, Middle, La	st)						
Examiner A. Coly, Town, or Location of Death Manor Care Ruxton Section of Death Section of Death Manor Care Ruxton Section of Death Section of D				Salome	a M.	Reard	on			'-	
Mannor Care Ruxton Towson			4a. Facility Name (If no					Location of Death	ilaj 20,		
Social Security Number 2.5 Sec 3.5 Sec	Examine		Manor (are Rux	ton		Towson			Balt	imore
Substitution Commonwealth Comm	Funeral			nber 6. S	6ex 7. Ag	ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		
10s. State 10s. County 10s. City, Town or Location 10s. City, Town or Location 10s. City Town				0/	□M 20XF	96 Yrs.	Months Days	Hours Min.		1908 I	
Rathleen Fairman Niece 2600 Meadowland Court Baltimore, Maryland 21234	yland					10c. City, Town or Lo	ocation				
Rathleen Fairman Niece 2600 Meadowland Court Baltimore, Maryland 21234	B-f.	Stor	Maryland	Baltim	ore	Towson					1 ☐ Yes 2 ☐XNo
Rathleen Fairman Niece 2600 Meadowland Court Baltimore, Maryland 21234	th the	ě	10e. Street and Number	er			10f. Zip Code		10	g. Citizen of What	Country?
Rathleen Fairman Niece 2600 Meadowland Court Baltimore, Maryland 21234	23a c		204 E. Jo	oppa Roa	d #615		2128	6		U.S.	Α.
Rathleen Fairman Niece 2600 Meadowland Court Baltimore, Maryland 21234	dea	ner			12. Was Decedent	Ever in U.S. 13.			ecity Yes or No-	14. Race - A	merican Indian,
Rathleen Fairman Niece 2600 Meadowland Court Baltimore, Maryland 21234	or Ite				1 ☐ Yes 2 💢	No			rican, etc.)		nite, etc.
Rathleen Fairman Niece 2600 Meadowland Court Baltimore, Maryland 21234	hours stural					16a, Dece	dent's Usual Occupa	ation	1		
Rathleen Fairman Niece 2600 Meadowland Court Baltimore, Maryland 21234	hin 72 3. 3n "ng Medik	plet	(Specify	only highest gra	ade completed)	(Give	kind of work done d DO NOT use retired;	luring most of work)	ing		
Rathleen Fairman Niece 2600 Meadowland Court Baltimore, Maryland 21234	giene giene er the	S		, (5,							nt Store
Rathleen Fairman Niece 2600 Meadowland Court Baltimore, Maryland 21234	be filk d oth event	Be									
Rathleen Fairman Niece 2600 Meadowland Court Baltimore, Maryland 21234	d Men d Men narke	ပ				40. 14. **		The state of the s		TOO THE DECEMBER OF	
Physician Medical Examiner 23a. Part . Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Medical Examiner 25a. Part . Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a. Part . Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a. Part . Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a. Part . Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a. Part . Enter the disease, or conditions as a consequence of): 25b. Due to (or as a consequence of): 25c. The part of the past 12 profiles? 25d. Was decedent pregnant so the past 12 profiles? 25d. Was decedent pregnant so the past 12 profiles? 25d. Was an autopsy performed by a profiles on the cause of death? 25d. Was an autopsy performed by a profiles on the cause of death? 25d. Was an autopsy performed by a profiles on the cause of death? 25d. Was as a referred to medical evanture? 25d. Place of Death (Check only one) 25d. December 10b. Was 10b. Wa	d 2 sh th and th and 7 lan traun										
Physician Medical Examiner 23a. Part . Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Medical Examiner 25a. Part . Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a. Part . Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a. Part . Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a. Part . Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a. Part . Enter the disease, or conditions as a consequence of): 25b. Due to (or as a consequence of): 25c. The part of the past 12 profiles? 25d. Was decedent pregnant so the past 12 profiles? 25d. Was decedent pregnant so the past 12 profiles? 25d. Was an autopsy performed by a profiles on the cause of death? 25d. Was an autopsy performed by a profiles on the cause of death? 25d. Was an autopsy performed by a profiles on the cause of death? 25d. Was as a referred to medical evanture? 25d. Place of Death (Check only one) 25d. December 10b. Was 10b. Wa	1 an Heal tem 2				NIECE	20b. Place of Dispo	sition (Name of				
Physician Medical Examiner 23a. Part . Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Medical Examiner 25a. Part . Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a. Part . Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a. Part . Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a. Part . Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a. Part . Enter the disease, or conditions as a consequence of): 25b. Due to (or as a consequence of): 25c. The part of the past 12 profiles? 25d. Was decedent pregnant so the past 12 profiles? 25d. Was decedent pregnant so the past 12 profiles? 25d. Was an autopsy performed by a profiles on the cause of death? 25d. Was an autopsy performed by a profiles on the cause of death? 25d. Was an autopsy performed by a profiles on the cause of death? 25d. Was as a referred to medical evanture? 25d. Place of Death (Check only one) 25d. December 10b. Was 10b. Wa	ages ant of ht: If it							.	מחסב מ	2.1+imono	Manuland
Physician Medical Examiner 23a. Part . Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Medical Examiner 25a. Part . Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a. Part . Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a. Part . Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a. Part . Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a. Part . Enter the disease, or conditions as a consequence of): 25b. Due to (or as a consequence of): 25c. The part of the past 12 profiles? 25d. Was decedent pregnant so the past 12 profiles? 25d. Was decedent pregnant so the past 12 profiles? 25d. Was an autopsy performed by a profiles on the cause of death? 25d. Was an autopsy performed by a profiles on the cause of death? 25d. Was an autopsy performed by a profiles on the cause of death? 25d. Was as a referred to medical evanture? 25d. Place of Death (Check only one) 25d. December 10b. Was 10b. Wa	ortar ortar injur										
Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Page 1	Dep Perr		Tal (I tac	rlm	-	and an extensive	or american			
Physician / Medical Examiner Sequentially list conditions, if any, leading to immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Final disease or conditions) Sequentially list conditions, if any, leading to immediate cause, Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last Due to (or as a consequence of): Chronic Yenu William Due to (or as a consequence of): Due to (or as a consequence of): Chronic Yenu William Due to (or as a consequence of): Due to (or as	dr servi		23a. Part1. Enter the	disease, or com	plications that cause	d the death. Do not en					Approximate
Due to (or as a consequence of): Sequentially list conditions, any, leading to immediate cause. Erret undergring that initiated events resulting in death) Last Due to (or as a consequence of):	Physician		Immediate Cause (Fir	1			may				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of):	/Medical			-	a. Due to (or as						
The first of the contribution of the contribut		. 1	Sequentially list condi	itions	b	Chronic	renu	1 1/2	اسمهر		
d. IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 2ves 2 No 9 Unknown 2 2 No 9 Unknown 2 2 No 9 Unknown 2 2 No 3 Probably 4 2 2 No 9 Post of completion of cause of death? 1 Yes 2 No 3 Probably 4 2 2 No 3 2 2 No 3 Probably 4 2 2	P ==	<u>ne</u>	if any, leading to imme cause. Enter Underly	ediate	Due to (or as	a consequence of):					
d. IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 2ves 2 No 9 Unknown 2 2 No 9 Unknown 2 2 No 9 Unknown 2 2 No 3 Probably 4 2 2 No 9 Post of completion of cause of death? 1 Yes 2 No 3 Probably 4 2 2 No 3 2 2 No 3 Probably 4 2 2	and trans	am	that initiated events		c						
FEMALE: 236. Did tobacco use contribute to the cause of death? 236. Did tobacco use contribute to the cause of death? 236. Was case referred to medical examiner? 236. Was case referred to medical examiner of Death 256. Place of Death (Check only one) 256. Place of Death (Check		_	rosuling in dodny Eds		Due to (or as	a consequence or):					
FFEMALE: 23b. Was decedent pregnant 1 Ves 2 No 3 Probably 4 Pregnant at time of death 5 Other (specify) 1 Ves 2 No 3 Probably 4 Presponding a time of death 5 Other (specify) 1 Ves 2 No 3 Probably 4 Presponding a time of death 5 Other (specify) 1 Ves 2 No 3 Probably 4 Presponding a time of death 5 Other (specify) 1 Ves 2 No 3 Probably 4 Presponding a time of death 5 Other (specify) 1 Ves 2 No 3 Probably 4 Proposition of cause of death 7 Ves 2 No 3 Probably 4 Proposition of cause of death 7 Ves 2 No 3 Probably 4 Proposition of cause of death 7 Ves 2 No 3 Probably 4 Proposition of cause of death 7 Ves 2 No 3 Probably 4 Proposition of cause of death 7 Ves 2 No 3 Probably 4 Proposition of cause of death 7 Ves 2 No 4 Proposition	cate to	dica			d						
23b. Was decedent pregnant in the past 12 morths? 23b. Was decedent pregnant at time of death 23b. Determined 23b. Mas decedent pregnant at time of death 23b. Determined 23b. Mas decedent pregnant at time of death 23b. Determined 23b. Determined 23b. Mas decedent pregnant at time of death 23b. Determined 23b. Dete	ertific ding p	Me	IF FEMALE:		220 If you system	of					
Section Sect	ath c	an			1 Live birth	2 Fetal death 3					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 1 Yes 2 No No No No 25. Was case referred to medical examiner? 1 Yes 2 No No No 25. Was case referred to medical examiner? 1 Yes 2 No No No 26. Place of Death (Check only one) 27. Manger of Death No No 28a. Date of Injury No No 28b. Time of Injury No No 28c. Injury at Work? No No 28d. Describe how injury occurred 28d. D	the a	slc	1 ☐ Yes 2 ☑ N			t time of death 5 L	Other (specify)				,
1 Yes 2 No 3 Probably 4 Ponknown 1 Yes 2 No 3 Probably 4 Ponknown 1 Yes 2 No 3 Probably 4 Ponknown 24a. Was an autopsy performed of cause of death? 1 Yes 2 No 3 Probably 4 Ponknown 24b. Was an autopsy performed of cause of death? 1 Yes 2 No 3 Probably 4 Ponknown 24c. Was an autopsy performed of cause of death? 1 Yes 2 No 3 Probably 4 Ponknown 24d. Was an autopsy performed of cause of death? 1 Yes 2 No 3 Probably 4 Ponknown 24d. Was an autopsy performed of cause of death? 1 Yes 2 No 3 Probably 4 Ponknown 24d. Was an autopsy performed of cause of death? 1 Yes 2 No 3 Probably 4 Ponknown 24d. Was an autopsy performed of cause of death? 1 Yes 2 No 3 Probably 4 Ponknown 24d. Was an autopsy performed of cause of death? 1 Yes 2 No 0 Probably 4 Ponknown 25. Was case referred to medical examiner? 1 Yes 2 No 0 Probably 4 Ponknown 25. Was case referred to medical examiner? 1 Yes 2 No 0 Probably 4 Ponknown 25. Was case referred to medical examiner? 1 Yes 2 No 0 Probably 4 Ponknown 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manor of Death 28d. Describe how injury occurred 28d. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Certifier (Check only one) 29d. Certifier 29d. Date signed (Month, Day, Year)	hat the	Ph		ant conditions	contributing to death I	out not resulting in the u	nderwing cause give	on in Part I	23e Did tob	acco use contribute	to the cause of death?
24a. Was an autopsy performed death? 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 1 Natural street 1 Natural str	ires t signe	þ	Tarris outsi		oritioating to adding	out not resulting at the c	riddifyllig cadso give	mini Care i.			
24a. Was an autopsy performed? 24a. Was an autopsy performed? 24b. Ware autopsy performed? 24b. Ware autopsy performed? 1 Yes 2 No Now	requ	etec									
Second Part	law has b	du							autopsy	prior t	o completion of cause of
25. Was case referred to medical examiner? 1	The cate I								репоrm 1 ☐ Yes 2	No 1 □ Y	
The state of the control of the co	cian ertific sctor.			to medical			12		n (Check only one)	
27. Manner of Death 1 Matural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 7 Suicide 4 Homicide 7 Suicide 7 Suicide 8 Homicide 7 Suicide 9 Suici	hysi his c	H .)	1 linpati		I 3 DOA	4 Nursing Ho			pecify)
Part	ing P	e e		5 Pending	(Month, Da		Work	.?	28d. Describe how	w injury occurred	
28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	eath or: /	cat									
29a. Certifier (Check only one) 29b. Signature and title of certifier (Month, Day, Year)	or At Ifter d Direct in by	Ħ			289. Place of in	jury - At home, farm, st tc. <i>(Specify)</i>	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or State)	Rural Route Number,
The state of the s	pital urs a sral C		20a Cartilla		Valeine T. C.	at any large test				(.)	
E E E D D D D D D D D D D D D D D D D D	24 ho Fun etely f	dica	(Check only 2	Medical Exa	miner: On the basis o	of examination and/or in	n occurred at the tim vestigation, in my op	e, date and place, pinion, death occurr	and due to the car red at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
	To the within To the compl.	Me	29b. Signature and titl	le of certifier			29c. License	number	29	d. Date signed (Mo	nth, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

5. Nirvara. mrs
31. Date filed Month. Bax Year)
MAY 3 1 2005 State Registrar

30. Name and address of prin who completed cause of death (Item 23a) (Type, Print)

5. HIYIWIG. M. 7505, USIX 35W 7505 USIX

29c. License number \$ 5 \times 749

29d. Date signed (Month, Day, Year)
05/31/05

TUNSON,

State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 9:39рт м Norman F. Ralston 19,2005 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda N/A If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 88 Yrs. Social Security Number 279–12–6913 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10**X**M 2□F Director 01/04/1917 MD Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medicul Examiner must be notified at OH 1 √Yes 2 No Fayette Washington Court House Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 429 East Court Street 43160 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? WWII 1208'es 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "naturel", or White 1 Yes 2 No δ 3XXVidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Contractor Construction h and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fift Department of Health and Mental Hy Imporaeit: If Item 27 is marked oth any injury or other treumatic event 900g. Be Thornton Fay Ralston Zeta Wolfe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 E. McPherson Avenue Findley OH 45840 Marie Dalley / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Commetery, crematory or other place)
Maple Grove Cemetery May 26, 2005 Findlay, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 Fast Fort Ave Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) illnun Physician ATHOTOSC LEREANI /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Box 68760, Certification; To Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No been signed by the atten should be detached for u 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) o. 9□ Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Miknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed' 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Cther. 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ R/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Maturai 5 Pending death. el or Attendi s after death. investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospitel o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) BETHEJDA BRIGH 8600 orb GETTEUN 60 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State 1 2005 Registrar

Norman

Herman 05-036	Ross,	Jr	amend item#20b-c,	Type or Print in E	Јаск ₋ Гр	delible ink	. Ensure Al	I Copies	Are Leg	ible.	
crn			1 - For Amend Item Registrar	1&2&Unpend 1te	d/Dep m 23a	artment of J 27, 28a-f. rtificate of	lealth and M Death GE	lental Hyg 344 6-3-6 tas R	iene 052 99. No. () (18082
	Physici /Medic	al	1. Decedent's Name (First, Middle, La HERM 4a. Facility Name (If not institution, giv	AN	R	Ab City Town	or Location of Death	2. Date of Deat Month May	Day 25	Year 2005 by of Death	3. Time of Death 6:30 P M
70	Examin	ier	5205 Bosworth Av	enue		Baltir	nore		N/A	y or Doain	
200	Funeral Director		5. Social Security Number 6. S 217 - 78 - 9891 19 Usual Residence of Decedent	ex 7. Age (In yrs.	3 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day,	year) 3,1961	9. Birthpl Coun	lace (State or Foreign try) RYLANO
	death with the Maryland ms 23e or 28e-f show	Director	10a. State 10b. County MARYLAND N	10c. Cit	/, Town or Lo	BAL	TIHORE		7		0d. Inside City Limits 1 Yes 2 No
	th with the		10e. Street and Number 5205 Bo	SWORTH A	VENUE	10f. Zip Code	2120	07 1	୭g. Citizen of ∠	What Coun	try?
036	s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygiene. Item 27 is marked other then "neturef", or Items 23e or 28e-1 show other treumetic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1. 12 Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ice - Americack, White, e	
21215-0036	d within 72 ho piene. r then "netur Ine Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(Give life.	dent's Usual Occul kind of work done DO NOT use retire	during most of work ad)	ing	16b. Kind of I		
Maryland 2	12 should be filed within 7 h and Mental Hygiene. 7 is marked other then "n treumetic event, tre Mad	To Be C	17. Father's Name (First, Middle, Last, HERMAN)	Ross		-	18. Mother's Name	e (First, Middle, M ADETTE	Maiden Suma	me)	non
	tand 2 st Health and tem 27 is n		19a. Informant's Name/Relationship (CECELIA WI)	LSON (AUNT)	19b. Maili	ng Address (Street	t and Number or Rura	TH' AVE	(12 n		D.21207
nore	ages 1 and of He		20a. Method of Disposition 1	Removal from State	lace of Disponent	nsition (Name of matory or other pla Ten) Park	(Ce)	Date	20c. Location	· City or To	
Baltimore,	permit. Pages 1 an Department of Heall Importent: If item 2 any injury or other gnce.		21. Signature of Funeral Service Licer	10	P.P.	SON TOX 2. Name and Addre	EST UG-	eown	~	INER INER	AL HOME
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.				or respiratory arre	est,		Approximate Interval Between Onset and Death
7	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequent)		tic intox	ication				
	ecuted and -transit	aminer	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	Due to (or as a consequent	uence of):						
8760,	cate be execul obysician and the burial-trar	m	that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	uence of):						
P.O. Box 68760,	law requires that the death certificate be ex as been signed by the attending physician a 2 should be detached for use as the burial:	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3	Ectopic pregnanc Other (specify)	у			ate of deliver	ry Day Year
	w requires that to be the properties of the prop	by	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did tob	_1/		e cause of death?
Division of Vital Records,	The ate h page	Completed						24a. Was an autops perform	v l	prior to con death?	osy findings available inpletion of cause of 2 No
fVit	ding Physiclen: The h. After this certificate ha funeral director, page	To Be	25. Was case referred to medical examiner? XYes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3□ DOA Oth	26. Place of Death ner: 4 ☐ Nursing Ho			her (Specify	at scene
ision o	To the Hospitel or Attending Physiclen: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	3 23 03	Found 6:21	P M 1□	ry at rk? Yes 2 XNo	28d. Describe ho	w injury occu	rred	unk
Div	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certif	4 Homicide	28e. Place of Injury - At ho building, etc. (Specify Found in res	sidence	eet, factory, office		City or Town Baltimor	e, MD	205 Bo	sworth Ave.
	e Hospi 24 hou e Funer letely fill	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medicel Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, deat ion and/or in	n occurred at the ti vestigation, in my o	me, date and place, opinion, death occurr	and due to the ca ed at the time, da	ause(s) and mate and place	anner as sta , and due to	ated. the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	Jano.	. /	29c. Licens		29	9d. Date sign		
			30. Name and address of person who	completed cause of death (Item	28a) (Type,	Print)		D. 7.		26, 20	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa			n Street	Baltimo	ore, Ma	aryLan	la 21201
	Registr	ar	MAY 3 1 2005	Keneud St.	good	/					

			For		aryland / Dep			lental Hy	giene		
			1. Decedent's Name (First, Middle, La	#18 PER FI	E G843 575	stifestant	Death	2. Date of De	Reg. No.	les .	8083
	Physici		M	st)	Ric	ci		Month MAY	Day	Year	3. Time of Death 3:15 M
	/Medic		4a. Facility Name (If not institution, giv	e street and number)			r Location of Death	/VIN/	4c. Count	ty of Death	ر.ان
			Creater Beltimone	Modersh	Center	Tow	SON		Balt	imore	
	Funeral		5. Social Security Number 6. S	Sex 7. Agu	e (In yrs. last birthda) Yrs.	/ If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da			ce (State or Foreign
	Director		220-54-939 / Usual Residence of Decedent		70			12/3	134	Italy	<u> </u>
yland	Mot		10a. State 10b. County		10c. City, Town or I	ocation				100	d. Inside City Limits
deeth with the Maryland	pa-1-se	ctor	MD Baltim	ore	Owing	gs Mills					1 ☐ Yes 2 No
ith	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Countr	y?
eth v	s 23a		9450 Wordsworth		F 1: 110	21117				aly	
	rai', or items 23a or 28a-f show Ezand per must be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces?		If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto I	Rican, etc.)		ace - Americar ack, White, et	
OU35 hours efter	tural', or el Eran	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Spec	fy: W	hite
	"natur edicul	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dec	edent's Usual Occup	ation during most of worki	na	16b. Kind of I	Business/Indu	stry
within 72	han "	mpje	Elementary/Secondary (0-12)	College (1-4or 5	ite.	DO NOT use retired	d)				
filed A	Hygie ther t		17. Father's Name (First, Middle, Last	n/a	Hom	emaker	18. Mother's Name	/First Middle		Home	
d be	sotal l ked o c eve	To Be	Don Antonio D'A					•			
shoul	and Mals marl	-	19a. Informant's Name/Relationship (19b. Mai	ling Address (Street	Maria + and Number or Rura				ode)
2 0	₹ 5° ₽		Nadia Tognocchi	/daughter	9612	Fable Di	r Owing	s Mills	. MD 2	1117	
or es	if of Heal		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20h Place of Dier			ate	20c. Location	- City or Tow	n, State
Pages	ant:		`4 □Donation 5 □ Other (Speci	(ه)	Lakevie	w Cemeter	ry 6/1/	05	Sykesy	ville, A	AD
Balti Permit.	Departm Importa any inju once.		21. Signature of Funeral Service Lice	S00		22. Name and Addre	ss of Facility uneral Ho	me of	Dulava	v Valle	v Inc
			23a. Part. Enter the disease, or com	lagle	I the death. Do not a	10 W. Pac	lonia Rd.	Timor	nium, A	1D 210	93 93
-			shock, or heart failure. List only Immediate Cause (Final	one cause on each lir	ne.	_	ig, such as saidias s	n roophatory at	1031,	, i	nterval Between Onset and Death
	ysician Vedical		disease or condition resulting in death)	a. andropul	movem 5 a consequence of):	Allure				In	mediate
Ex	aminer			0	est failure					5	VPAR C
771	=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	←Due to (or as	a consequence of):		, ,				yo. —
6U, be executed	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Pulmonm	y hyperteusi	ON AND CH	remic obs	TRUCTIVE	disea	se a	ier 5 years
876U, sate be ex	siclen and burial-transit		l	Al Hand	y hypertensi a consequence of): APY LALLATI	the same	مناب ع	Tival	Lunal.		14 110100
	the	edicai		d. Chemid MER	MP ENGLIATE	on meny	JOR MEGIN	SILAKE	Lympho	mv1 0	1 years
Hecords, P.O. Box 6 The law requires that the death certifi	attending p	D/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. D	ate of delivery	
death	e atte	icia	in the past 12 months? 1 ☐ Yes 2 🗷 No	4☐Pregnant at		□Ectopic pregnancy □ Other (specify)	/		M	lonth D	ay Year
at the	signed by the a	Physician/M	9 Unknown	9□ Unknown							
S, les th	igned be de	þ	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause giv	en in Part I.				cause of death?
ord requir	been si should	ted						1 🗆 ነ	res 2 No	3 Probac	oly 4 🗆 Unknown
Records he law requires	hasb e 2 st	Completed						24a. Was autop	sv	prior to comp	y findings available pletion of cause of
	certificete has l irector, page 2 s							1X Yes	rmed? 2□No	death? 1 Yes 2	□ No
Of VITAL Physician: T	is certif directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ★ No	Hospital:		Oth	26. Place of Death				
o g	S E		1 ☐ Yes 2 No 27. Manner of Death	1 A Inpatie	ry 28b. Time	of 28c. Injur	y at 2	ne 5 ∐ Resid 28d. D <i>e</i> scribe h			
o guille	ath. r: After e funera	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	y Year) Injury		k? Yes 2 □ No				
DIVISION I or Attending	after death. Director: A I in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be determined		ury - At home, farm, s	treet, factory, office	2	28f. Location (S City or Tox		ber or Rural f	Route Number,
	rs aft rat Di	Cer		N. C.							
DIVISION To the Hospital or Attending	within 24 hours after d To the Funeral Direct completely filled in by	edical	(Gneck only 2 Medical Exe	nysician: To the best of miner: On the basis of	examination and/or i	ith occurred at the tin	ne, date and place, a	and due to the	cause(s) and ri date and place	anner as stat	ed. ne cause(s)
the	thin 2 the mpler	Med	one) 29b. Signature and title of certifier	and manner sta	ated.	29c. Licens			29d. Date sign		
70	¥ + 8		<i>A</i> √2/ <i>A</i>	A h. x	X MI				-/20	2/05	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
1.	1		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type	Print)	38352		2/0	1100	
0	٧		Roth R Schwar	Tz. M.D.	670/ N.	Thanks S	J. BALT.	MODE	Marin	Land	21204
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature		1 1000	va o	- my		
	Registi	ar	MAY 3 1	2005	THE BE	boarder					
DHMH	17 Rev 1/2	001	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Par SN.	11000						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 1:30 PM M May 26, 2005 Carolyn Shamleffer Rowe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Meadows Health Care Center Baltimore Glen Arm If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Months Hours Min. 89 Yrs Director MD 215-01-3570 05/11/1916 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23s or 28s-1 show the Medical Examiner must be notified at 1 Yes 2 No Director MD Glen Arm Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21057 USA 11630 Glen Arm Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Z No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📈 No Specify: 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Own Home Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker permit, Pages I and 2 should be file Cepertment of Health and Mental Hy Importent: If Item 27 is marked othe any Injury or other treumatic event, origin 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Carrie Bauer Howard Shamleffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Rowe /Son 216 Clayhill Circle Cockeysville, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 9 Other (Specify) 28 May Beltsville, Maryland ⁴ 4 □ Donation Chesapeake Crematory Inc. 2005 21. Signature of Funeral Service License 22. Name and Address of Facility Cremation and Funeral Alternatives 47 racen 8717 Green Pastures Drive Baltimore, Maryland 21286 23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirts, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death

WEEKS METASTATIC ADENO CARCINOMA Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): ADENOCARCINOMA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physicien Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2XINo 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation nerel Director: A 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 C Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 51228 Hamona 90 palon Address of Son who completed cause of death (Item 23a) (Type, Print) NC (ROSS ROADS #15 RAMANA 32 legistrar's Signature 31. Date filed (Month, Day, Year) State MAY 3 1 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month MARGARET MARIE RILEY Mei 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner VSYS ta 5 Anni VVV no If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day) 5. Social Security Number 7. Age (In yrs. ast birthday) Birthplace (State or Foreign Country) **Funeral** Months 216-14-7312 1 - M 200 82 Director Yrs. MD 06/09/1922 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ral', or itams 23a or 28a-f show Examiner must be notified at Director 1 ☐ Yes 🏋 ဩNo MD ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 NEW JERSEY AVENUE 21061 USA Funerai permit. Pages 1 and 2 should be filed within 72 hours after deal. Department of Health and Mental Hygiene. Important: If ten 27 is marked other the eny injury or other traum. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify Specify: WHITE þ 3 X Widowed 4 ☐ Divorced leted 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Compl Elementary/Secondary (0-12) College (1-4or 5+) TELEPHONE OPERATOR TELEPHONE COMPANY 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HENRY A. SCHREINER MARIE E. BLIMLINE ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MRS. JUDY SMOOT / DAUGHTER 909 ELMHURST ROAD, SEVERN, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/3/2005 HOLY CROSS CEMETERY BROOKLYN PARK, MD ¹ 4 □ Donation 5 □ Other (Specify) Funeral Servige License 22. Name and Address of Facility SINGLETON FUNERAL HOME 1 SECOND AVENUE SW, GLEN BURNIE, MD 21061 MO1415 23a. Part! Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician resulting in death) /Medical Due to (or as a conseque ce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated executes). Due to (or as a consequence of): Examine burial-transit V Υ that initiated events resulting in death) Last Due to or as a consequence of) The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Vital Records, Be Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certiticate has autopsy performed 2 No 1 ☐ Yes 2D No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification; To 1 Minpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. D te of Injury (Month, Day Year) 28b. Time of Injury Division 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Diractor: 6 Could not be determined 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 Homicide within 24 hours a To the Funeral L TC crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 Name and address of person who completed cause of death (Item 23a) (Type, Print) C 2005 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1- State of Maryland /		artment rtificate			and Me		jiene	005	5 1	8086
	Dhucisi		Decedenl's Name (First, Middle, Last)						2. Date of Dea Month			'ear	. Time of Death
	Physici /Medio		John Dorman Rus	st							2005		:00 PM M
	Examir	er	4a. Facility Name (If not institution, give street and number)		4b. City, T	Town, or	Location of	Death		4c.	County of	Death	
			Manor Care Bethesda 5. Social Security Number 6. Sex 7. Age (In yrs. last	hirthday)	If Under		Bethe:		8. Date of Birth			ontgo	
	Funeral Director		220 - 12-9015	Yrs.		Days	Hours	Min.	(Month, Day	, Year)			(State or Foreign
	P		Usual Residence of Decedent						August 1	L e 2 .	920	riary	y Lanu
	show	-	10a. State 10b. County 10c. City, To	wn or Lo	cation								Inside City Limits
	the M	Director	Maryland Montgomery 10e. Street and Number		100 7		ethes	da					1 ☐ Yes 2 📉 No
	with Be or				10f. Zip (Code	0001	_	1	Og. Citi		al Country?	
	ms 23	Funeral	6417 Winnepeg Road 11. Marital Status 12. Was Decedent Ever in U.S.	13. 1	Was Decede	ent of Hi	2081		ify Yes or No- ican, etc.)			ted S	
9	after or Ite	Fur	1 □ Never Married 2 M Married Armed Forces? 1 M Yes 2 □ No If Yes, Give		_			, Puerto R	ican, etc.)			White, etc.	,
ဗ္ဗ	72 hours after death with the Maryland natural', or Items 23e or 28e-t show deal Examinat he redified at	d by	3 Widowed 4 Divorced Year or Dates: WWII		1 □ Yes 2	X NO	<i>Specity:</i>				Specify:	Wh	nite
<u>7</u>		Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usuat kind of work DO NOT use	done d	uring most	of working	,	16b. Kir	nd of Busin	ness/Indu <i>s</i> t	ry
12	e filed within al Hygiene I other than " vent, the wer	dmc	Elementary/Secondary (0-12) College (1-4or 5+) 5+		ninist			ffio		D.,1	140	Uaa 1 +1	h Service
9	illed Hygi other	a)	17. Father's Name (First, Middle, Last)	Aui	птитъс				First, Middle, I			пеатс	n Service
lar	should be ind Mental marked o	To B	John Dorman Rust, Sr.						Marga	ret	Wien	ers	
Maryland 21215-0036	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)	∌b. Mailir	g Address (Street a	nd Number	r or Rural	Route Number	, City or	Town, Sta	ate, Zip Cod	de)
2`	1 and Health Iem 27						Road		nesda,				
Baltimore,	0 0		1 Rusial C. V. Cramation 2 Removal from State	of Dispo tery, cren 1 tgon	sition (Name natory or oth	e of ner place	9)	Da Mar		20c. Lo	cation - Ci	ty or Town,	Slate
턡	it. Pa rtmer rtant: njury		* 4 □ Donation 5 □ Other (Specify) Cre 21. Signature of Fyrigral Service Licensee	emăto	rium	Inc.		28, 2	005	Bet	hesda	a, Mar	cyland
Ba	permit. Page Department Important: II any injury or once.		21. Signature of Portland Service Licensee	Be Be	thesd thesd	la-Cl	hevy (Marv1:	Chase and 2	Inc. 20814-3	755 501	7 Wi	rune: scons:	ral Home/ in Avenue
г			23a. Part 1. Enter the disease or complications that caused the death. D shock, or heart failure. List only one cause on each line.	o not ente	er the mode	of dying	, such as c	cardiac or	respiratory arre	e <i>s</i> t,		Inte	proximate erval Between
	Physician		Immediate Cause (Final disease or condition a. Bilateral Pne	2umo1	nia					On	set and Death		
	/Medical Examiner		resulting in death) Due to (or as a consequence										
		<u>ا</u>	Sequentially list conditions, if any, leading to immediate b. Sepsis Due to (or as a consequence)	e of):			 _						
H	uted d ansit	Examiner	Cause Disease or injury) i cond								
, O	exectan and rial-tra	Exa	resulting in death) Last C. Ellu Stage Ref Due to (or as a consequence		Iseas							_	
8760,	icate be executed physician and s the burial-transit	dlcal	d. Prostate Cand	er									
Вох 6	eath certific attending p	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy							2	3d. Date o	f delivery	
Ö	death	sicla	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death		Ectopic pred Other (spec	gnancy cify)				- 1	Month	,	Year
P.0	at the de by the stached	Phys	9 ☐ Unknown 9☐ Unknown										
Records,	The law requires that the death certific site has been signed by the attending p bage 2 should be detached for use as	by	Part II. Other significant conditions contributing to death but not resulting	in the ur	iderlying car	use give	n in Part I.						iuse of death? 4 Munknown
ecc	e law requ has been je 2 shoul	ompleted							24a. Was ar		24b. Wer	e autopsy f	indings available tion of cause of
		Соп							perform	ned?	dea	th? Yes 2	
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					of Death (Check only on	e)			
	Physi this c	5	1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatient 2 ☐ ER/C 27. Manner of Death 28a. Dale of Injury 28b				4 K Nuis		5 Reside			Specify)	
Division of	Attending Physician: r death. sector: After this certific. by the funeral director.	ertification;	1 X Natural 5 ☐ Pending (Month, Day Year)	Time of Injury	M 28	C. Injury Work	at ? es 2 ⊟ N		d. Describe ho	w injury	occurred		
/isi	I or Attencatter death Diractor: I in by the	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - Al home.	farm, stre					f. Location (Str	reet and	Number o	or Rural Rou	ute Number.
ā	in Signature	Cert	4 ☐ Homicide determined building, etc. (Specify)						City or Town	, State)			
	To the Hospital or within 24 hours atte To the Funerel Dir. completely filled in I	Medical	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowled 2 Madical Examiner: On the basis of examination a and manner slated.	je, death ind/or inv	occurred at estigation, in	the time	e, date and inion, death	place, an	d due to the ca at the time, da	u <i>s</i> e(s) a ate and p	and manne place, and	or as stated due to the	cause(s)
	To th Withir To th comp	M	29b. Signature and title of certifier	in	29c.	Licen <i>s</i> e	number		29	d. Date	signed (A	fonth, Day,	Year)
	141		put von	<i>l'</i>	11	Ι	2027	74			May 2	26, 20	005
	157		30. Name and address of person who completed cause of death (Item 23a				_ 1	M -	1 1 00	017			
	Sta	te	Kirti Vohra, M.D. 7710 Bradley Bo 31. Date filed (Month, Day, Year) 32 Jegistrar's Signature			ethe	esda,	Mary	Tand 20	1817			
	Registr		MAY 3 1 2005 32 degistrar's Signature	190	ede								

			For State Registrar	State of Marylar		artment of Heal		ental Hygie	2005	18087
	Physici		1. Decedent's Name (First, Middle, Las GBDLG T	"OBINSDA)			2	Date of Death	Day Year	3. Time of Death G.4/ A M
	/Medio Examir		4a, Facility Name (If not institution, give	street and number) 2000	MMF ST	4b. City, Town, or Loca		MD 2123	4c. County of Deat	1 4 4 4 4 7
	Funeral Director		5. Social Security Number 6. Social Security Number 6. Social Security Number 7.2	ex 7. Age (In yrs.	last birthday) Yrs.		Jnder 24 Hrs. 8 ours Min.	Date of Birth (Month, Day, Yes	9. Bin 201925 Mar	hplace (State or Foreign Juntry) yland
	yland how		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	he Mar 8a-f sl	ector	MD		Balti					1√∑Yes 2□No
	3a or 3	Dir	10e. Street and Number 4303 Springdale	Avenue		10f. Zip Code 2120	07	10g.	Citizen of What Co USA	untry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "neturel", or items 23e or 28e-f show any injury or other treumatic event, the Medical Examinar must be notified at once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ፟█ Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	li li	Vas Decedent of Hispan Yes, specify Cuban, Me ☐ Yes 2 No Sp	ic Origin? (Speci exican, Puerto Ri ecify:	fy Yes or No- can, etc.)	14. Race - Ame Black, White Specify: 1	
Maryland 21215-0036	ithin 72 hou te. ten "neture Medical E	npleted	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	ucation	(Give	ent's Usual Occupation kind of work done during OO NOT use retired)	most of working	161	b. Kind of Business/	
d 21	filed w Hygier other th		12 17. Father's Name (First, Middle, Last)	0	steel	worker unk 18.1	Mother's Name (i	First, Middle, Maid	den Sumame)	
ylan	Mental Mental arked c	To Be					Via C	raft		
	alth and 2 sho		19a. Informant's Name/Relationship (7 Frenchette Robin		19b. Mailin	g Address (Street and N	lumber or Rural F	Route Number, Ci	ty or Town, State, Z	Tip Code) unk
altimore,	Pages 1 ament of Helent If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☑ Other (Specify	Removal from State	Place of Disposemetery, crem	sition (Name of natory or other place)	Dat	е 200	Location - City or	Town, State
Balt	permit. Depart Import eny inj		21. Signature Funeral Service Licen-	Wade, Director	st Ba	Name and Address of Pate Anatomy 1timore, MD	Board 21201		altimore	Street
ı	e e e		23a. Part 1. Enter the disease, or come shock or heart failure. List only of	one cause on each line.	h. Do not ente	or the mode of dying, suc	ch as cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death
	/mysician /Medical		Immediate Cause (Final disease or con Hion resulting in death)	a	uence of):	DISEASE				MMTHS
	Examiner	Ļ	Sequentially list conditions,	b. CARCIND:	MA	OF STD	MACH			ype
	outed id ansit	Examiner	The any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events causing in death) Last							. 8
8760,	icate be executed physician and the burial-transit	ai Exa	resulting in death) Last	Due to (or as a consequent	uence of):					
9	ntificate ng phy: s as the	Medical	IF FEMALE:	O.						
Division of Vital Records, P.O. Box	The law requires that the death certific tie has been signed by the attending p page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of di 9 □ Unknown	Ideath 3□	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
rds, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions co	CTIVE PULM	ulting in the un			23e. Did tobacc	_	the cause of death?
al Reco	: The law ricate has be	Completed	HYPERTENSI	0 N				24a. Was an autopsy performed 1 ☐ Yes 2 🔀	? prior to c	topsy findings available ompletion of cause of 2 No
	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 ☑ Inpatient 2 ☐	ER/Outpatient	Other	Place of Death (6 □Other (Spec	(A)
o u	tending Physieath.		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	280	Describe how in		ny)
)ivisio	or Attend ifter death Director: / in by the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ome, farm, stre	M 1 ☐ Yes et, factory, office		. Location (Street City or Town, St	and Number or Rui ate)	ral Route Number,
_	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical Ce	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of my knowiner: On the basis of examination and manner stated.	wledge, death tion and/or inv	occurred at the time, da estigation, in my opinion	te and place, and , death occurred	d due to the cause at the time, date	o(s) and manner as and place, and due	stated. to the cause(s)
	To the Within To the compl	~ 1	29b. Signature and title of certifier		10	29c. License num	ber I G	29d.	Date signed (Month	, Day, Year)
	Try - 4 min.mad.r yanaman		30. Name and address of person who country of the c	ompleted cause of death (Item	23a) (Type, F	Print) JUD (U	E 57 6	ALTIMOI	LE STRE	67
	Sta	te	31. Date filed (Month, Day, Year) MAY 3 I 200	Registrar's Signa	ture	on VIIMAY	t, M	N 212 3	3	
	Registra	ar	INI S T ZUC	Some to	19:3					

State of Maryland / Department of Health and Mental Hygiene 05 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** May 26, Henry Eugene Wiers Schmidt 2005 11:25 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 13, 1915 9. Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 ☐ F 296-09-4350 90 Ohio Director Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other then "neturel", or itams 23a or 28a-f shov treumatic event, the Medical Examiner must be incitined at 1 ☐ Yes 2 No Director MD Baltimore Towson 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 1055 W. Joppa Rd. # 318 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 No If Yes, Give ШШII 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Valve & Coupling permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygient Important: If item 27 is marked other the any injury or othar treumatic event. Manager/ Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Henry John Schmidt Marie Wiers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Doris Schmidt/wife 1055 W. Joppa Rd. #318 Towson, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 06/01/2005 Baltimore, MD. 21. Signatur of Fyneral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pelvic AND LIEFT HUMERUS Fracture Sweeks disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Fall equantiany list consitions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): the attending physician Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown Ö 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Osteuporasis 1 Yes 2 No 3 Probably 4 □Unknown Completed CEREBROVASCULAR DISEASE 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \times$ Other (Specify) Hospice 2 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred FEII Certification; 28b. Time of 28c. Injury at Work? FROM After To the Hospital or Attending Injury 1 Natural 5 Pending 1045 AM 1 ☐ Yes 2 ☐ No investigation 2 Accident MAY 4 2005 STANDING + WITHEDSED Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide NURSING FALLITY within 24 hours a 1055 W. JOPPARD TOWSEN, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 58303 26 2005 Charles Street 15+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6601 N. CHARLES MD AARON Bowson. MD 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

a

一大のころり

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Sinis 5:30 AM 2005 28 stamatios /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner Brightwood Lutherville Baltimore Eldercare 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

72 Yrs. Months Days Hours Min. April 24,1933 Genesis Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 105-46-1186 Greece Director Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hyglene. Important: If Item 27 Ia marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercities must be notified at page. 10a. State 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2XXNo Be Completed by Funeral Director Maryland Baltimore Owings Mills 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code 3114 Walnut Avenue 21117 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 XXIVo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Psychiatrist Medicine 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Eleni Demas Ioannis Sinis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 3114 Walnut Avenue Martha Sinis Wife Owings Mills, Maryland 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 5-30-05 Cub Hill 4 ☐ Donation 5 ☐ Other (Specify) Demetrios Cemetery Mary land 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signut Fund Service Licenses 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or comblications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Physician /Medical Immediete Ceuse (Final disease or condition resulting in death) · METASTATIC RENAL CELL CARCINOMA Examiner Medical Certification: To Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. To the Hospital or Attending Physician: The law requires that the within 24 hours effer death.

To the Funeral Director: After this certificeta has been signed by a completely filled in by the funeral director, page 2 should be dated. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. 29a Certifier 29c. License number 29b. Signature end title of certifier クリフのから WAY 28 2005 WI Di 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) TOWNER CHO 21204 2505 GJC GU THIS w MULUE Eur 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

Registrar

MAY 3 1 2005

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2 Date of Deeth 1. Decedent's Name (First, Middle, Last) May 29, 2005 Year Lillian G. Schwarz 12:45 PM 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Name (If not institution, give street end number) Oak Crest Center Parkville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Oct. 5, 1913 7. Age (In yrs. lest birthday) 5. Social Security Number Birthplace (State or Foreign Country) Days Hours 1 □ M 2 □ F Yrs. Mary Tand 216-34-9348 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No MD Baltimore Parkville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8800 Walther Blvd. #1515 21234 **AZII** Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status . Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 Ž No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Julius Ernest Anna Dorthea Hormess 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8800 Walther Blvd. #1515, Parkville, MD Charles Schwarz/husband 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Nother (Specify) Entombment Dulaney Valley Gardens 06/02/2005 Timonium, MD. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. of Fundal Service Licensee 1050 York Road, Towson, MD 21204 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 100 3 Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Examiner Examiner sician and burial-transit Division of Vital Records, P.O. Box 68760. ettending physician for use as the buna Physician/Medical signed by the et id be dateched for þ Completed Be Certification: To After this funeral dir spital or Attendir nours aftar death. neral Director: Al To the Hospital or within 24 hours aff To the Funeral Di

Physician

/Medical

Examiner

Director

Funeral

2

Completed

Be

Funeral

Director

7 is marked other than "natural", or Items 23a or 28a-4 show trsumstic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

permit. Peges 1 and 2 should be filed within Daparament of Health and Mental Hygiena. Important: If item 27 is merked other than any Injury or other them.

Physician

/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Deeth 5 Pending 1 Tes investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner stated.

State

Registrar

Medical

(Check only one)

31. Dete filed (Manth

29b. Signature end title of cenifie

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) 2 F.L Lowson

Yar 2005

32. Registrer's Signature

29c. License number

29d. Date signed (Month, Dey, Year)

			1 - For State Registrar	State of M	laryland	-	artment of F	leaith and N Death		ene 0 0 5	18091
	Physici:	an	Decedent's Name (First, Middle	Last)					2. Date of Death	Day Yea	3. Time of Death
	/Medic	cal	HATTONY	Jantiago		ucc7	th Oh T		5	27 05	
	Examin	ier	4a. Facility Name (If not institution University of Maryla	1 1 1 0	(on)	4	Gal L	Location of Death		4c. County of De	ath
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		irthplace (State or Foreign Country)
ш	Director		584-87-9965	1 XX M 2□F	25	Yrs.	Months Days	Hours Min.	(Month, Day, SEPT 12	1979 PU	ERTO RICO
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				10d. Inside City Limits
	Mary I sh	ţō	MARYLAND HARF	ORD CO		ABERD	EEN				1 ☐ Yes 2 🔀 No
	or 28e	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What (Country?
	ath wi	ral	753 CAMBRIDG				2100			U.S.A.	
	ltems	Funeral	11. Marital Status 1 ☒ Never Married 2 ☐ Married	12. Was Deceden Armed Forces ad 1 ☐ Yes 2 🔀	?	13. \	Vas Decedent of F Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	
936	ours after death with the Marylan rat', or items 23a or 28e-1 show Examinatination to the confilled with	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			X Yes 2□ No	Specify: Pue	rto Rica	n Specify:	Puerto Rican
21215-0036	72 hours after death with the Maryland "natural", or Items 23a or 28e-1 show ultral Examiting must be multiled at	Completed	15. Decedent (Specify only highes			16a. Deced	lent's Usual Occup	pation during most of work	ina	6b. Kind of Busines	s/Industry
121	within 72 ho piene. r than "natur I'in Wedicol	mpl	Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	OO NOT use retire	d)		DIED ON	T
	Hyg the int,		12th grade 17. Father's Name (First, Middle, 1	.ast)		MA	TERIALS		e (First, Middle, M	PIER ON Maiden Sumame)	E .
lan	d ta b 9	o Be	ANTONIO SANTIA	GO-RIOS				MARIC	EL SANTI	AGO	
Maryland	d 2 should th and Men 7 is marke traumatic		19a. Informant's Name/Relations			19b. Mailin	g Address (Street	and Number or Rur	al Route Number,	City or Town, State	Zip Code)
	C = N L		Antonio Santiag	o-Rios/Fath			Cambridg			Md., 210	
Baltimore,			20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation		Ceme	netery, cren eter1a	natory or other pla Municip	al	Date 2	oc. Location - City o	or Town, State
Ħ		i	'4 □Donation 5 □ Other (Sp. 21. Signat → of Funeral Sepace I			Penoel	as Name and Addre	\$ 06-0 ss of Facility			UERTO RICO
B	permit. Departr Importa any inj	. 10	Jak Sm			WM	C BROWN	COMMUNIT		L HOME-HA ERDEEN, M	RFORD, P.A. D 21001
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	d the death.						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	- a Acute	2 Lyn	nohot	lastic, L	eukemia			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a conseque	nce of):					
		ier	Sequentially list conditions if any, leading to immediate	b. Due to (or a	s a conseque	nce of):			-		
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	с.							
50,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or a	s a conseque	nce of):					
68760,	physicate t	edical		d							
Вох (eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. Date of d	elivery
	death	Physiclan/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic pregnancy Other (specify)	<i>'</i>		Month	Day Year
P.O	that the de ed by the detached	Phy	9 ☐ Unknown Part II. Other significant condition		but not result	ing in the w	adorhing source gu	en in Dert I	23a Did tob	acco uco contributo	to the cause of death?
ds,	signed d be de	d by	Tatti. Ottor significant somanie	is contributing to double	but not result	ing in the di	idenying cause gre	on in Facts.	1 🗆 Ye	* 1	Probably 4 Unknown
Records,	w requir s been s should	ompleted		-					24a. Was an	24b. Were a	autopsy findings available
Re	The lavate has page 2	omp							autopsy perform 1 Yes 2		
Vital		Be C	25. Was case referred to medical examiner?					26. Place of Deat	h (Check only one		20110
of V	Physician: this certific al director,	မ	1 ☐ Yes 2 X No	Hospital: 1 Inpat		R/Outpatien		4 Nursing Ho		nce 6 Other (Sp	ecify)
uc UC	ling After uner	tlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investig		ay Year)	8b. Time of Injury	28c. Injur Wor M 1	yat k? Yes 2⊡No	28d. Describe hor	winjury occurred	
Division	deal deal ctor: y the	fical	3 ☐ Suicide 6 ☐ Could r	ot be 28e. Place of Ir	njury - At hom	e, farm, str	eet, factory, office				Rural Route Number,
ā	s afte	Certification:	4 Homicide determine	building, e	itc." (Specify)				City or Town,	State)	
	To the Hospitel or A within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier Certifyin (Check only one)	Physicien: To the bes exeminer: On the basis and manner s	of examinatio	edge, death n and/or inv	occurred at the tirestigation, in my c	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner a te and place, and du	as stated. ue to the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of ertifier				29c. Licens			d. Date signed (Mor	. N
6	0	18	- with	M.D				16435515	731	MAY, 27	,2005
1/) '	8	30. Name and addres of person FLORIN	vho completed cause of SELARY	22	SG	REENE !	T BAC	TIMORE	MD eyze	10
	Sta Registr		31. Date filed (Month, Day, Year)	2005 32 Regis	trar's Signaty	e for	and a			•	

			1 - For State Registre AMEND ITEM #	State of Maryland					18092
	Physici	20	Decedent's Name (First, Middle, Last)	T 0	-17	Jogsp of Deal	2. Date of		3. Time of Death
	/Medic	al	LIZQDETA 4a. Facility Name (If not institution, give.	street and number)	nith	4b. City, Town, or Location	May	4c. County of De	16 12:15 M
	Examin	er	3537 Old Fr	ederick R	d.	Baltimore	2	NIA	
	Funeral Director		5. Sold Section 5. Sold Sectin 5. Sold Section 5. Sold Section 5. Sold Section 5. Sold Section	7. Age (In yrs la	Yrs.	If Under 1 Year If Und Months Days Hour	der 24 Hrs. 8. Date of March	of Birth 9. B Day, Year 9/5 N	irthplace (State or Foreign COURDLINA
	ryland how		10a. State 10b. County		, Town or Loca				10d. Inside City Limits
	the Ma	Funeral Director	MD N/A 10e. Street and Number	Ba	ltimore			10g. Citizen of What 0	1 Yes 2 No
	h with 23a or	al Dir		lerick Rd.		10f. Zip Code 21229		USA	ountry ?
	er deat	uner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	6. 13. Wa	as Decedent of Hispanic es, specify Cuban, Mexi	Origin? (Specify Yes can, Puerto Rican, etc	or No- 14. Race - An Black, Wh	
036	ours aft rel', or Everti	l by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 [Yes 22 No Spec	ify:	Specify:	Black
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or Items 23a or 28a-1 show the Madeal Evertiner reval Le rollified at	Completed by	15. Decedent's Edu (Specify only highest grade	cation e completed)	(Give kir	nt's Usual Occupation nd of work done during n NOT use retired)	nost of working	16b. Kind of Busines	s/Industry
212	od withi rgiene. er than	Somp	Elementary/Secondary (0-12)	College (1-4or 5+)	RECOVE	. /),	Hospital	
and	should be filed within nd Mental Hygiene. markad other than imatic event, ITEM	Be	17. Father's Name (First, Middle, Last)			18. Mc		iddle, Maiden Sumame)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "neturel", or Items 23a or 28a-f show any injury or othar treumatic event, the Madical Examination and the notified at ODGS.	To	UNK . 19a. Informant's Name/Relationship (Typ	рө, Print)	19b. Mailing			umber, City or Town, State,	Zip Code)
	of Health of Health litem 27 i	•	DUE EdmondSon - 1) 20a. Method of Disposition	nece-in-law	3537 ace of Disposit	Old Freder	rick Rd.	20c. Location - City of	739
mor	Pages ent of t nt: If ite ry or of		Burial 2 Cremation 3 R	emoval from State		tory or other place)	1	S Kington	
Baltimore,	permit. Pages Department of t Importent: If ite any injury or of		21. Signature of Funeral Service Livenson		1000	Name and Address of Fa	cility		
	205 g g		23a. Pant 1 Enter the disease, or compli	cations that caused the death.	Do not enter	O Fredhill	on fast E	Home P.A. Balto Moa	Approximate
	Physician		shock, or beart failure. List only or Immediate Cause (Final disease or condition	se cause on each line.	15			.,,	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):	DECLIC	2 KT		
	BYE.	Jer	Sequentially list conditions, and any leading to immediate cause. Enter Underlying	Due to (or as a cons -qu	ence of:	DE COS	21/1		1
	ecuted and I-transit	Examlner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	osel	Mosh			
8760,	cate be executed physician and the burial-transit	dlcal E		L .	ence or).				
9		Medi	IF FEMALE:						
Box	that the death certif ed by the attending detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3□E	ctopic pregnancy Other (specify)		23d. Date of de Month	elivery Day Year
P.O.	at the c d by the etached	Physi	9 🗆 Unknown	9□ Unknown					
	Se ng eq		Part II. Other significant conditions con	tributing to death but not resu	iting in the und	erlying cause given in Pa		Did tobacco use contribute 1 ☐ Yes 2 ☐ No 3 ☐ F	to the cause of death? Probably 4 AUnknown
Records,	e law requit has been s je 2 should	Completed							autopsy findings available completion of cause of
a E								performed? death?	
f Vital	S S B	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) No	lospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient	Othor	ace of Death (Check o Nursing Home 5 XI)	<i>nlv one)</i> Residence 6 □Other (Sp.	ecify)
o uo	ding Ph	lon:	27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		ribe how injury occurred	-
Division		Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor	ne, farm, stree	M 1 ☐ Yes 2 t, factory, office	28f. Locati	on (Street and Number or F	Rural Route Number,
Ö	itel or ars afte ral Dir			building, etc. (Specify)				r Town, State)	
	To the Hospitel or Attentwithin 24 hours after deatl To the Funeral Diractor:	Medical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examination	sician: To the best of my know ner: On the basis of examinati and manner stated.	rledge, death o on and/or inves	ccurred at the time, date stigation, in my opinion, c	and place, and due to leath occurred at the ti	the cause(s) and manner a me, date and place, and du	s stated. e to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	TON		29c. License numbe	or C	29d. Date signed (Mon	th, Day, Year)
•	1,		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type Pri	1 VC414	8	MITTY C'	(DO)
	(WARREN J.	JY1714 35	3021	and an ic	8 NEAC	bara 4	21215
	Sta Registr		31. Date filed (Month, Day, Year) MAY 3 1 2005	32. Registrar's Signati	Social S				

			Please 1	Type or Prin State of Ma						-		•	100	0.0
			1 - State RegistrAMEND ITEM #8		•	•				vicillai	Reg. N	. 000	100	193
			Decedent's Name (First, Middle, Last		JU4.J) J. J. J. P.	ווטייפע	0 0. 0		2. Date	of Death		3. Time	of Death
	Physicia		William A. Smit							Mont	23	2005	6:0	0 A M
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City,	Town, or Lo	cation of Deatl	_		lc. County of Dea		0 11
	LXamiii		312 S Fagley				Bal	timor	·e					
	Funeral	Т	5. Social Security Number 6. Se		e (In yrs.	last birthday)		r 1 Year If	Under 24 Hrs. lours Min.	8. Date	of Birth—2	7-1941 ⁹ . Bir	thplace (State	e or Foreign
	Director		216-36-6860	5 M 2□F		64 Yrs.	, aronario	Days	10010		4-41	VA		
	pue *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside	City Limits
	Aaryle r • ho	ö	MD			ltimo								es 2 🗆 No
	28e-	rect	10e. Street and Number			TCIMO	10f. Zir	Code			10a. C	Citizen of What Co	ountry?	
	e filed within 72 hours after death with the Marylend of Hygiene. of hygiene "natural", or fleme 23a or 28e-f ehow ont, the Madical Examinar must be notified at	Funeral Director	315 N. Ellwood	Δνο				224			US		,	
	death me 2:	era	11. Marital Status	12. Was Decedent B	Ever in U.	.S. 13.			nic Origin? (S Mexican, Puer	pecify Yes		14. Race - Ame		
0	or ite		1 ☐ Never Married 2 ☐ Married	Armed Forces?	10	í	it Yes, spe 1 ☐ Yes		мехісап, Риел <i>Specify:</i>	o Hican, et	C.)	Black, Whi		
200-	rait', c	l by	3 ☐ Widowed 4 ♣ Divorced	If Yes, Give Year or Dates:			1 1 1 1 1 1 1	213440 3	эр ө спу.			Specify: O 1	ack	
ה ה	72 h natu dicel	Completed	15. Decedent's Edu (Specify only highest grad			(Give	kind of wo	al Occupatio	n ng most of wo	king		Kind of Business	/Industry	
7	Althin ne.	mpi	Elementary/Secondary (0-12)	College (1-4or 5	+)			se retired)				actor		
7	iled v Hygie her t		6th 17. Father's Name (First, Middle, Last)			Truc	K Dr		. Mother's Nar	ne /First M		iler		
yland	Q 22 Q	Be	Willie Smith					1	larian			on ourname,		
_	2 should be and Mental Is marked raumatic ev	은	19a. Informant's Name/Relationship (7)	vpe. Print)		19b. Mailir	na Address					or Town, State,	Zip Code)	
2	id 2 s Ith an 27 is trau	1	Margaret Davis		er)		•	·			_	MD 212		
ກົ	ss 1 and 2 should of Health and Men item 27 Is marke cother traumatic		20a. Method of Disposition		20b. P	Place of Dispo	sition (Na	me of		Date		Location - City or		-
9	Page: ent of nt: If i		1 ☐ Surial 2 ☐ Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)			. Car	-	nilei piace)	5-2	7-05	D11	ındalk,	MD	
altimore,	permit. Pages 1 a Department of He Importent: If Item eny injury or othe		21. Signature of Funeral Service Licens		,,,,,		-	nd Address o		-		is Jr.		
ă	Ped La		11/Inley	Man		2	007	Easte	rn Av	e. Ba	alto.	MD 21	231	
П			23a. Part1. Enter the disease, of comp shock, or heart failure. List only o	lications that caused	the deat	h. Do not ent	ter the mod	de of dying, s	uch as cardia	or respira	tory arrest,		Approxin Interval	Between
	Physician		Immediate Cause (Final disease or condition	Lund		ncer							Onset an	nd Death MNH S
	/Medical		resulting in death)	Due to (or										
	Examiner		Sequentially list conditions	b										
	pd jij	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause Julistate or injury	Due to (or as	a conseq	uence of):								
5	be executed ician and burial-transi	Examiner	that initiated events resulting in death) Last	c	a consed	uence of):								
Š	eath certificate be ex attending physician for use as the buria				2 0011004	331.00 017.								
20	death certificate e attending phys d for use as the	Physician/Medical		d										
	certif nding use a	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			_					23d. Date of de	livery	
POX	death s atter	ciar	in the past 12 months?	1□Live birth 4⊡Pregnant at			∃Ectopic p ∃ Other (s;					Month	Day	Year
j.	the che	hys	9 Unknown	9□ Unknown										
7	The law requires that ite has been signed b age 2 should be deta	by P	Part II. Other significant conditions co	ntributing to death be	ut not res	ulting in the u	inderlying	cause given i	n Part J.	23e.	Did tobacci	o use contribute t		of death?
Ë	w require been sig should b										1 🗌 Yes	2 □ No 3 X P	robably 4	∐Unknown
ပ္သ	aw re	piet								24a.	Was an autopsy	24b. Were a	utopsy finding	gs available
Ĕ	The lay	Completed								1 🗆	performed?	death?	2 □ No	
Vital Record	icien: T certificat rector, pi	Be	25. Was case referred to medical examiner?						6. Place of De	ath (Check				
0	Physic this co	To.	1 Yes 2 No	Hospital: 1 Inpatie	-	ER/Outpatier		grandly in the second			-	6 □Other (Spe	ecify)	
	ding P. h. After 1 funera	iuo	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injui (Month, Day	ry y Year)	28b. Time o Injury		28c. Injury at Work?		28d. Des	cribe how in	jury occurred		
<u>s</u>	tend death tor: /	cati	2 Accident investigation 3 Suicide 6 Could not be	-	At h		M		2 □ No	295 000	tion (Stroot	and Number or A	ural Pourto M	ium has
UIVISION	or At after of Direction by	Certification:	4 Homicide determined	28e. Place of Inju- building, etc	c. (Specif	(y)	reet, ractor	y, office		City	or Town, Sta	ate)	urar riodie iv	umber,
_	a Hospitel or Attendi 24 hours after death. a Funerel Director: A etely filled in by the fu		29a. Certifier 1 Certifying Phy	/sician: To the best	of my kno	wiedge deat	h occurred	Lat the time.	date and place	and due t	o the cause	(s) and manner a	s stated.	
	24 hos P Fun etely	edical		iner: On the basis of and manner sta	f examina									e(s)
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Me	29b. Signature and title of certifier				29	c. License n	umber		29d. [Date signed (Mon	th, Day, Year	-)
	->-0		Clustin -	Hann				D60	372		N	lay 24	200	5
	1		30. Name and address of person who co		eath (Iten	n 23a) (Type,	Print)					00s. sc	,	-1817 17 -1
	(600 N. WOLFE	ST. R	BALT	TIMOR	E, N	D	2128	7				
	Sta		31. Date filed (Month, Day, Year) MAY 3 1 200	32 Registra	ar's Signa	ture	and I							
	Registi	ar	MAY SIZUI	Salle.	2 86	Pallet	- Section							

1			For State	State of Maryland / Department	artment of Health and I <i>rtificate of Death</i>	Mental Hygi	ene 005	18094
			Registrer		runcale of Death	2. Date of Death	g. No.	2 Time of Dooth
	Physici	an	1. Decedent's Name (First, Middle, Last	to Kes		Month Month	Day Yea	
	/Medic		MUNH S	10	T	May	17 200	0 1308
	Examin	er	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		4c. County of De	
			10407 Farrar Aven		Upper Marlbord If Under 1 Year If Under 24 Hrs.			George's
ш	Funeral		5. Social Security Number 6. Se	X 7. Age (In yrs. last birthday) M 2 F Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 5 9. 8	Country) // /
	Director		Usual Residence of Decedent	7 33		//-/	17-21	VA.
	and and		10a. State / 10b. County	10c. City, Town or Lo				10d. Inside City Limits
	sho	ō		orges chel	ten ham			1 ☐ Yes 2 No
	Ne N	ect	10e. Street and Number	erges crie;	10f. Zip Code	10	og. Citizen of What (Country?
	after death with the Maryland or Items 23a or 28e-f show of refundst be notified at	Funeral Director	10407 EA	RRAR	20623			5 A.
	eath	eral			Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - An	nencan Indian,
		ŭ.	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 Yes 2 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	o Rican, etc.)	Black, Wi	
36	100	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify:	white
5-0036	72 hours "natural", Jical Ext		15. Decedent's Edu	ucation 16a. Dece	dent's Usual Occupation		16b, Kind of Busines	ss/Industry
215	_ 3	plet	(Specify only highest grad	le completed) (Give	kind of work done during most of wor DO NOT use retired)	rking	.1 11	
212	with iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	NURSE		HEALT	n CARE
	ba filed within tal Hygiene. d other then 'event, I'm Ma	O	17. Father's Name (First, Middle, Last)	- ·	18. Mother's Nar	ne (First, Middle, M	Maiden Sumame)	
Maryland	D 25 D 0	00	Tosenh	STOKES	UN	KNOW	N	
2	id N	ဥ	19a. Informant's Name/ elationship (T		ing Address (Street and Number or Ru			, Zip Code) 20678
≥	nd 2 salth ar alth ar 27 ls		JAMES W:	IL: AM S SON	334 Dewler	OD LAN	10, OD E	Rod Mal
a,	s 1 and Heal	1	20a. Method of Disposition	20b. Place of Dispe	osition (Name of	Date 2	20c. Location - City	or Town, State
altimore,	9 = 10		1 ☐ Burial 2 🔀 cremation 3 ☐ l	Removal from State	matory or other place) 'EW CREM. 5	1315	N. Int Ak	alt nod
Ħ	t. Pa tmer tent tent ijury		'4 □ Donation '5 □ Other (Specify)	A AIL	TW CHEFT. 3	4303	DUNCER	1 HOLL
Bal	permit. Par Departmen Importent: eny injury once.		21. Signature of Funeral Servi & Licens	2000	2. Name and Address of PA4	1.2 S.A.	E BAL	The Horse
	20 = 0 O		Musey	(par je)				
L.			23a. Part1. Enter the disease. or comp shock, or heart failure vist only of	lications that caused the death. Do not en one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
14	Pnysician		Immediate Cause (Final disease or condition	. Hypertensive	cardiovescular	disease.		Onset and Death
	/Medical		resulting in death)	Due to or as a consequence of):				
	Examiner		Conventially list conditions	b				
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):				
	outed Id ansit	Examiner	Cause (Disease or injury that initiated events	C				
o,	be axecuted ician and burial-transit		resulting in death) Last	Due to (or as a consequence of):				
8760	ate be hysicia the bu	dicai		d				
68		O I						
Вох	requires that the death cartific leen signed by the attending p hould be detached for usa as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of c	delivery
Ď	atte affor	cla	in the past 12 months? 1 ☐ Yes 2 🕱 No		□Ectopic pregnancy □ Other (specify)		Month	Day Year
P.O.	that the di ed by the detached	ysi	9 Unknown	9□ Unknown				
	that ed b deta	Į P	Part II. Other significent conditions co	entributing to death but not resulting in the t	underlying cause given in Part I.	23e. Did tob	acco use contribute	to the cause of death?
ds	uires signi	q p	Curhosis of the	e liver due to chio	nic disholism	1 ☐ Ye	s 2 No 3	Probably 4 Unknown
Ö	w require been si should t	ete				24a. Was ar	24h Were	autoney findings available
3eC	= (0 -)	Completed				autopsy	y prior t	autopsy findings available o completion of cause of ?
Vital Records,	. (0 12		Lancier			100 Yes 2		
Ħ	Physicien: this certific ral diractor,	Be	25. Was case referred to medical examiner?	Hospital:		ath (Check only one	9)	
-	d si	P.	Tes 2 No	1 ☐ Inpatient 2 ☐ EH/Outpatie	and the same of th		nce 6 COther (S)	pecify) Scene
Ę.	ing P	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe ho	w injury occurred	
<u>S</u> .	eath or: /	cati	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No			
Division	irect irect	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Str City or Town		Rural Route Number,
	rs af	Cel						
	hour hour	cal		/sician: To the best of my knowledge, dea iner: On the basis of examination and/or in				
	To the Hospitel or Attending Pl within 24 hours after death. To tha Funeral Director: After th completely filled in by the funeral	Medical	one)	and manner stated.				
	To t To t	Σ	29b. Signature and title of certifier		29c. License number	29	d. Date signed (Mo	nth, Day, Year)
			Jashar M	reentsery MD	OCME		May, 18,	2005
			30. Name and address of person who o	completed cause of death (Item 23a) (Type	, Print)			
			Tasha Z Gre	enberg M.D.	111 Penn Stree	t Baltimo	ore Maryla	and 21201
	Sta	ite	31. Date filed (Month, Day, Year)	32. Redistrar's Signature				
	Regist		MAY 3 1 2005	Bearing H. Goory	6 A			

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 9:01 A M May 28, 2005 Ρ. Sharma Yash /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□F Months Days Hours Yrs Director 218-66-7768 17,1934 70 India Aug. Usuel Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evant ear must be notified at 1X Yes 2 □ No Maryland Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 546 Ednor Road Funeral 20905 United States death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Evant 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 25 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 5+ Real Estate Realtor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jaga Nath Sharma Parkash Wati Prabhkar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Raj Sharma/Son 8658 Reservoir Road Fulton, Maryland 20759 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crematory 5/30/05 Odenton, Maryland 21. Signal re of Funeral Service Licensee Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 unita X M00957 Homos 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARDS **Physician** RESPIRATION FAILURGE disease or condition resulting in death) Hills /Medical Due to (or as a consequence of): Examiner DILATED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760 the attending physician pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ 1 Yes 2 No 3 Probably 4 Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed/2 1 ☐ Yes 2 ☐ No 212 No 1 🗌 Yes Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifice 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 2 7 No 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5/28/05 May 28, 2005 062588 saoure, no 0, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7513 NOW HAMPSHIRE AVE, TOWORDA PARK MD 20912 JUDITH MUSHOUA 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 3 1 2005 Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

			1 - For State of Ma			of Health an	-	giene	5 1809	7
	Dhu.i.		Decedent's Name (First, Middle, Last)				2. Date of De Month	ath	3. Time of Dea	ath
	Physic /Medi		Emil D. Ta	aborsky			May 2		4:47 A	М
	Exami	ner	4a. Facility Name (If not institution, give street and number)			wn, or Location of D	eath	4c. County o		
	Eunaval	7	Upper Chesapeake Medical Cer 5. Social Security Number 6. Sex 7. Age	nter (In yrs. last birthda		Air Year If Under 24 I	Hrs. 8. Date of Bir	Harfo		reiar
	Funeral Director		219-05-9532 ¹♥™ ²□F	86 Yrs.	Months F	Days Hours N	Ain. 8. Date of Bir (Month, Da	23,1919	9. Birthplace (State or Fo Country) Maryland	, u.g.
	pu .		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Logation					To a State
	daryla f sho	5		•					10d. Inside City Li	
	und 21215-0036 be ilied within 72 hours after death with the Maryland tial Hygiene. ad other than "natural", or Itema 23a or 28a-f show event, the Medical Examirer must be notified at	Funeral Director	Maryland Baltimore 10e. Street and Number	Tows	10f. Zip Co	ode		10g. Citizen of Wi		
	h with	O E	708 Saylor Court			21286			S . A .	
	r deat	iner	11. Marital Status 12. Was Decedent Ev Armed Forces?	ver in U.S. 13		nt of Hispanic Origin? Cuban, Mexican, Pi	(Specify Yes or No		- American Indian, , White, etc.	
4	36 safte	by Fu	1 Never Married 2 Married 1 M Yes 2 No	∘ WW II	1 ☐ Yes 2 ☐			Specify:	, wille, etc.	
4:4:4	215-0036 thin 72 hours aft e. an *natural; or Medical Exami	ed b	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education	16a. Dec	cedent's Usual C	Occupation		16b. Kind of Bus	White	
7	215	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+	(Gir	ve kind of work of DO NOT use	done during most of retired)	working	Tob. King or bas	Hosamadany	
	Oden et the	Com	4	·	Manage	r		Printin	g Company	
	S d la b	Be	17. Father's Name (First, Middle, Last)			18. Mother's	Name (First, Middle,	Maiden Sumame)	
N.	ryla hould d Mer marke	70	Albert Taborsky 19a. Informant's Name/Relationship (Type, Print)	105 146	ilian Addusas (C	Jose Street and Number of		atousek	T-0	_
ळ	re, Maryla s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		Louise Taborsky Wife		Saylor		Towson, Ma		,	
5138165	ore, M jes 1 and 2 t of Health if Item 27 i		20a. Method of Disposition	20b. Place of Dis		of	Date Date		ity or Town, State	
10	Pages nent of i		1 ☐ Burial 2 【Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify)	1	•	Corp. 5-3	31-2005	Towson	Maryland	
	Baltimore, permit. Pages 1 ar Department of Hea Important: If then any Injury or other once.		21. Signature (Savior Licensee						1 Home, Inc	
	m #9F#9		land tagan			York Road	Towson,	, Marylan	d 21204	
			23a. Part1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line	he death. Do not e	enter the mode o	of dying, such as care	diac or respiratory a	rrest,	Approximate Interval Between Onset and Deat	
•	Enysician /Medical		Immediate Cause (Final disease or condition resulting in death)	ē ,						
	Examiner		Canaashi	consequence of):	- Cail	11100			5 days	
		ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	consequence of	r fail	uic,			3 Earys	1
- 4	acutec ind transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Pulmon Due to (or as a	ary En	ubolis	m .				
5	icate be executed physician and sthe burial-transit		11	consequence of):						
8		dica	d. 17 9767	torvsios [
35	Box 68 eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of		_			23d. Date	of delivery	
MRH 38	Of VItal Records, P.O. Box (Physician: The law requires that the death certif this certificate has been signed by the attending rat director, page 2 should be detached for use a	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 1 ☐ Live birth 2 4 ☐ Pregnant at tire		B □Ectopic pregr □ Other <i>(speci</i>			Monti		
NA N	IS, P.O. Iries that the designed by the a	Phys	9 Unknown 9 Unknown							
	1S, ires th signed t be d	by	Part II. Other significant conditions contributing to death but Multi-Infarct Demen		underlying caus	se given in Part I.	23e. Did to	/	ute to the cause of death Probably 4 Dunkn	
	Records,	etec	Mari Private Derrent	.(/ -			-	· · · · · · · · · · · · · · · · · · ·		
3	The lav	Completed					24a. Was autop perfo	rmed? pri	ere autopsy findings avail or to completion of cause ath?	of
(E)	VITAL I	Be Co	25. Was case referred to medical			26 Place of I	1 ☐ Yes Death (Check only o		Yes 2 No	
3	1 VI	ToB	examiner? 1 Yes 2 No Hospital: 1 Impatient	t 2 ER/Outpati	ient 3 DOA		g Home 5 ☐ Resid		(Specify)	
Baborsk	L grant		27. Manner of Death 28a. Date of Injury 1 ✓ Matural 5 ☐ Pending (Month, Day)	Year) 28b. Time Injury	of 28c.	Injury at Work?	28d. Describe h	now injury occurred	1	
8	VISION Attending r death, sector: After	icati	2 Accident investigation		M	1 ☐ Yes 2 ☐ No	006 1		0 10	
10	DIVISION I or Attending after death. Director: Afte	Certification;	4 Homicide determined 236. Place of Injury building, etc.	y - At home, farm, s (Specify)	street, tactory, of	пісе	City or Tox	vn, State)	or Rural Route Number,	
•	DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ti		29a. Certifier 12 Certifying Physician: To the best of	my knowledge, dea	ath occurred at t	the time, date and pla	ace, and due to the	cause(s) and manr	ner as stated.	-
	the Ho in 24 the Fu pletel	edical	(Check only 2 Medical Examiner: On the basis of e	examination and/or	investigation, in	my opinion, death of	ccurred at the time,	date and place, an	d due to the cause(s)	
	With To t	Σ	29b. Signature and with of certifier		_	icense number		29d. Date signed (
					I V	001842	4 1	1ay - 29	8-2005	
	10+1		30. Name and address of person who completed cause of dea B. Payekh MD. 190	ath (Item 23a) (Type	e, Print)	Road,	Fallchm	mn 2	1047	
	Sta	ite		's Signature	170151	-0014		1 1 7 1		
	Regist	ar	MAY 3 1 2005 Agence	's Signature	de la company de					

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	Marylan		artment of H tificate of I		d Mental Hy	giene Reg. No.	005	18098
			1. Decedent's Name (First, Middle, La.	st)	_				2. Date of De	ath Day	Year	3. Time of Death
	Physicia /Medic		HENRY T	WILLIA	AMSON				May.	24	2005	12:31 PM
	Examin		4a. Facility Name (If not institution, give	street and numb	er)		4b. City, Town, or		eath		punty of Death	1
			Union Hospital				1 1	27			ecil	
	Funeral		5. Social Security Number 6. S	ex 7. ÖZM 2□F		last birthday)	If Under 1 Year Months Days	If Under 24 I Hours N	Ain. (Month, Da	ıy, Year)	Cou	place (State or Foreign Intry)
	Director		219-12-6819 Usual Residence of Decedent		8	3			MARCH	21 192	22 MA	ARYLAND
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation	-				10d. Inside City Limits
	Many a-f sh lied	ţo	MARYLAND HARFO	RD CO		DAR	LINGTON					1 ☐ Yes 2X No
	h the	Director	10e. Street and Number				10f. Zip Code			10g. Citizer	n of What Cou	untry?
	th wil		1228 HOLLOWAY RO	DAD			210	34		υ.	S.A.	
	ems erns	Funeral	11. Marital Status	12. Was Decede Armed Force		.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin?	? (Specify Yes or No uerto Rican, etc.))- 14.	. Race - Amer Black, White	
36	or it	by Fu	1X Never Married 2 Married	MYes 2 If Yes, Give		i	1 ☐ Yes 2 ☐XNo	Specify:				LACK
Ö	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. In marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show umatic event, Ira M. of call Exercities mail be notified at	d be	3 ☐ Widowed 4 ☐ Divorced	Year or Date	9S: 	16a Decer	lent's Usual Occupa	ation		16h Kind	of Business/li	ndustry
5	in 72	Completed	(Specify only highest gra	de completed)		(Give	kind of work done o	during most of	working	TOD. IVAIIG	01 00311103371	idustry
77	with liene.	l mo	Elementary/Secondary (0-12) 7th grade	College (1-4	or 5+)	COO	К			PRI	IVATE	
פַ	illed Hygi other	Be C	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Middle			
<u>a</u>	Abnta herta	TOE	ROMON PHILLIP WI	LLIAMSON	GERT	RUDE V. W	ILLIAN	MSON				
Maryland 21215-0036	and hard is ma		19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (Street a		r Rural Route Numb			ip Code)
	₽ £ № ₽		Edith Gordon/Sis	ter	lasi s			Rd.	Darlingto			
Ore	Pages 1 nent of H int: If ite iry or otl		20a. Method of Disposition 1 Burial 2/CyCremation 3	Removal from St	1 0	riace of Dispo semetery, cren	sition (Name of natory or other plac	e)	Date	20c. Loca	tion - City or T	own, State
altimore,	tmen tant: jury		*4 □Donation 5 □ Other (Specif	· ·	M		REMATORY		-26-05	BALTI	IMORE,	MARYLAND
Bal	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signatur of Funeral Service Licer	See 1		W		COMMU	NITY FUNE PHIA BLVD			RFORD, P.A. MD 21001
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cau one gause on eac	ised the deat th line.	h. Do not ent	er the mode of dyin	g, such as car	diac or respiratory a	rrest,		Approximate Interval Between
l.	Pnysician		Immediate Cause (Final disease or condition	1 Bilo	teral	10600	- pyec	monia				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a conseq	uence of):	•					
		-	Sequentially list conditions, if any, leading to immediate	b. — Due to (or	as a conseq	uence of):						
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events									
o Î	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or	as a conseq	uence of):						
8760,	ite be nysicia he bu	dlcal	(d								
9	ing ph	a)	IF FEMALE:									
Вох	death certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?		h 2∐Feta	il déath 3 [Ectopic pregnancy			230	d. Date of deliv Month	very Day Year
O.	The law requires that the death certificate has been signed by the attending lagge? should be detached for use as	Physiclan/M	1 Yes 2 No	4∐Pregnar 9□Unknow	nt at time of d m	leath 5∟	Other (specify)					,
<u>а</u>	that the de ed by the detached	Ph	Part II. Other significant conditions of	ontributing to dea	th but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did	obacco use	contribute to	the cause of death?
Vital Records,	w requires that been signed b should be det	d by	Coronary ar	tery d	(1081	10			1 🗆	Yes 2	No 3□Pro	babiy 4 Dunknown
COL	w req beer shou	lete	Deci Alecal	tery d	di	1011			24a. Was	an 2	24b. Were aut	opsy findings available
Re	The lavate has	Completed	10/1/190141	1,1010	(Ci)	(4) 0				med?	death?	ompletion of cause of
tal		Be C	25. Was case referred to medical					26. Place of	1 Yes Death (Check only	2 Z No	1 🗆 Yes	21 110
	ys dis	0	examiner? 1 Tes 2 No	Hospital:	atient 2	ER/Outpatien	t 3 DOA Oth	0.00	ng Home 5 ☐ Res		Other (Spec	ity)
n of	0 0 0	T:uc	27. Manner of ath	28a. Date of (Month,	Injury Day Year)	28b. Time of	28c. Injun Worl	/ at </td <td>28d. Describe</td> <td>how injury o</td> <td>occurred</td> <td></td>	28d. Describe	how injury o	occurred	
Siol	Attending ir death. ector: Af el by the fur e	catle	2 ☐ Accident investigatio				M 1 🗆	Yes 2 □No				
Division	= 2 # o	Certification:	3 Suicide 6 Could not b 4 Homicide determined	289. Flace 0	f Injury - At ho , etc. <i>(Specif</i>	ome, farm, str y)	eet, factory, office		28f. Location (City or To	Street and N wn, State)	Number of Hui	ral Route Number,
	To the Hospital or Attendin Within 24 hours after death. To the Funeral Director: At completely filled in by the fun	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the b niner: On the bas and manne	is of examina	owledge, death ution and/or inv	occurred at the tin vestigation, in my o	ne, date and pi pinion, death o	lace, and due to the occurred at the time,	cause(s) and pl	nd manner as lace, and due	stated. to the cause(s)
	To the vithin comp	Me	29b. Signature and title of a ertifier	Jan 1	us		29c. Licenso		190	29d. Date s	signed (Month)	Day, Year)
h	, ,		30. Name and addess of person who		of death (Item		Print)	7				
_	/		/) 11 / 5 / 1	no mo			chital !	56 15,	ow ST 8	CIKT	04, 1	15915 00
	Sta Registr		31. Date filed (Month, Day, Year) MAY 3 1 20	100	gistrar's Signa	4	ast 1					
	ricgisti	-cat	MAISTE	UJ ASSE	Wind .	155						

DHMH 17 Rev 1/200

		1 - State Registrer	of Marylar		artment of rtificate c		and Mental	Hygien Reg. N	GUU2	18099
Physic		1. Decedent's Name (First, Middle, Last) Mary Elizabeth Wee	ks				2. Date of Month Ma		7 2005	3. Time of Death 6:30 P M
/Medi Examir		4a. Facility Name (If not institution, give street and Future Care Chesapea	ke		Arno1				c. County of Dear	
Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☑ Usual Residence of Decedent	7. Age (In yrs. F 94	last birthday) Yrs.	If Under 1 Ye		8. Date o Min. (Month 11-1	f Birth , Day, Yea -1910	r) 9. Birt	thplace (State or Foreign puntry) PA
Maryland I-f show	tor	10a. State 10b. County MD Anne Arunde1	1	ty, Town or Lo						10d. Inside City Limits
h with the	Funeral Director	10e. Street and Number 8011 Warton Court			10f. Zip Cod 211			10g. C	Citizen of What Co USA	ountry?
urs after deat al', or Items 2 xaminer mu	by Funer	1 Never Married 2 Married 1 Yes	Decedent Ever in U d Forces? es 2 X No , Give or Dates:		Was Decedent of Yes, specify C	Juban, Mexican	gin? (Specify Yes o , Puerto Rican, etc.	r No-)	14. Race - Ame Black, Whit Specify:	
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "neturel", or Items 23e or 28e-f show aumatic event, Ite Medical Examinat must be notified at	Completed	15. Decedent's Education (Specify only highest grade comple) Elementary/Secondary (0-12) College	ed) ge (1-4or 5+)	(Give	dent's Usual Oc kind of work do DO NOT use re Assemb1	ne during most tired)	of working		Kind of Business stinghou	-
ould be filed Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last) William Henry Duke					r's Name <i>(First, Mi</i> ie Belle		en Sumame)	
and 2 sho salth and I n 27 is ma		19a. Informant's Name/Relationship (<i>Type, Print</i>) Mr. William Arnold / se	on	8011	Warton	Ct, Pa	r or Rural Route N sadena, N	ID 21	1122	
permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal for 4 Donation 5 Other (Specify)	om State	cemetery, crei	osition (Name of matory or other en Ceme	place)	Date 6/1/05		Location - City or en Burnio	
permit. Departr Importe any inju		21. Signature of Funeral Service Licensele	M01	364 1	Second	dress of Facility Ave SW	Singleto , Glen Bu	on Fur urnie	neral Ho MD 2106	me P.A. 1
Physician		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	nat caused the deal on each line.	th. Do not ent	ter the mode of	dying, such as	cardiac or respirato	ry arrest,		Approximate Interval Between Onset and Death
Medical /Medical Examiner	Examiner	Sequentially list conditions, if any, issuing to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events	to (or as a consection	ophou = ce of):	nt'a	~				years
death certificate be executed to attending physician and of for use as the burial-transit	dlcal	d	, outcome of pregn						22d Data of da	hone
that the death or the beath or the detached for u	Physician/Me	in the past 12 months?	ve birth 2 ☐ Feta regnant at time of d nknown	aldeath 3[□Ectopic pregna □ Other (<i>specify</i>			_	23d. Date of del Month	Day Year
w requires that the s been signed by th should be detache	٥	Part II. Other significant conditions contributing Weight 1085, Co	to death but not res	sulting in the u	nderlying cause	given in Part I.	0		o use contribute to 2 No 3 □ Pr	the cause of death?
The law ate has b page 2 sl	Completed	rastular dise	ase,	,00	topol	120V	> 8	Vas an autopsy performed? es 200 N	prior to death?	utopsy findings available completion of cause of 2 No
Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	☐Inpatient 2☐	15D/O	4 0F 004	A	of Death (Check or rsing Home 5 🗆 i		2 CO# /C	- 4.1
Attending Physic death. ector: After this by the funeral d	H-		ate of Injury Month, Day Year)	28b. Time o Injury	f 28c. l	njury at Work? I □ Yes 2 □ N	28d. Descr		ury occurred	city)
P # # □	Certification:	3 Suicide 6 Could not be 28e. P	lace of Injury - At h uilding, etc. (Speci	ome, farm, str	reet, factory, offi	сө	28f. Locati City of	on (Street a Town, Sta	and Number or Ru te)	ural Route Number,
the Hospitel in 24 hours at the Funeral C	edical	29a. Certifier (Check only one) Certifying Physician: To Medical Examiner: On the and of the control of the con	the best of my kno ne basis of examina nanner stated.	owledge, deatl ation and/or in	h occurred at the vestigation, in m	e time, date and ny opinion, deat	d place, and due to th occurred at the ti	me, date ai	nd place, and due	to the cause(s)
To the Hi within 24 To the Fi	×	29b. Signature and title of certifier	0	~	29c. Lie	ense number D4	1955	29d. D	S-29	h, Day, Year)
0	1	30 Name and address of person who completed	cause of death (Ite	m 23a) (Type,	Veter	anst	Lishu	Ruy	Mull	ersville
St	ate	31. Date filed (Month, Day, Ayer) 1 2005	2. Redistrar's Sign	ature	doorse	,		0		1021108

			Please	Type or Prin							_		
		For State Registrar		State of Ma	aryland .	•	artment of F <i>rtificate of</i>	Health and M <i>Death</i>	Mental Hy	ygiene Reg. No.	005	18	100
• Physicia		1. Decedent's Name		ast)					2. Date of D Month	eath Day	Year	3. Time	e of Death
/Medic			MARCIA			WO			MAY	2.5	2005	,	7 A M
Examin	er			ve street and number)			_	or Location of Death		4c. (County of Dea	n N/A	
Funeral		5. Social Security N	HOSPIT lumber 6.		(In yrs. last		If Under 1 Year	If Under 24 Hrs.	8. Date of B	irth	9. Bir	thplace (Sta	te or Foreign
Funeral Director		212-07-	6235	1□M 2\ F	92	Yrs.	Months Days	Hours Min.	DEC. 2	5,1912	2	ountry)	MD
pu 🛾		Usual Residence of 10a, State	f Decedent 10b. County		10c. City, T	own or Lo	cation					10d. Inside	City Limits
Aaryla f sho	or	MD		IMORE	,,,		IMORE						'es 2 🕅 No
the 7	Director	10e. Street and Nui		THORE		D, (L)	10f. Zip Code			10g. Citiz	en of What C	ountry?	
ath with the Marylan 23s or 28e-f show ust be matified at	alD	16 OLD	COURT R	DAD				21208				USA	
after death w	Funeral	11. Marital Status		12. Was Decedent Armed Forces?		13. \	Was Decedent of I	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or N Rican, etc.)	10- 1	4. Race - Ame Black, Whi		
rs afte	by Fu	1 Never Marr 3 X Widowed	ied 2 Married 4 Divorced	1 ∐Yes 2 💢 i If Yes, Give Year or Dates:	10		1 ☐ Yes 2 💢 No	Specify:			Specify:	WHI	TE
72 hours after death with the Maryland "netural", or Items 23s or 28e-f show edical Examitter and by molified at			15. Decedent's 1	Education	1	16a. Deced	dent's Usual Occup	pation		16b. Kir	nd of Business	/Industry	
	Completed	(Spec	cify only highest g ondary (0-12)	College (1-4or 5	i+)	life. I	DO NOT use retire	during most of work ad)	ang				THING
be filed within ital Hygiene.		47.5 to 10 No. 10	8			SALE	S	18. Mother's Nam	o /First Adiabal		IL CHIL	DKEN.	5
be be	Be	17. Father's Name		st)		KRAM	IFR		•	e, maiden .	<i>Sumame</i>)	KRA	USS
2 should be and Mental is marked eumetic ev	۲			(Type, Print)				L		ber, City or	Town, State,		
P 5 7 5 0		FLOREN	CE POLLA	CK / DAUGHT	ER	995	5 MIDDLE	MILL DRI	VE - 01	WINGS	MILLS,	MD 2	1117
es 1 g of He of He if item				☐Removal from State	cem	etery, crer	matory`or other pla	100)	Date)
Pag tment tent: I		' 4 Donation	5 ☐ Other (Spec	cify)	BETH					OSEDALE			
permit Depar Impor eny in	JOSEPH KRAMER REBECCA 19a. Informant's Name/Relationship (Type, Print) FLORENCE POLLACK / DAUGHTER 20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - Ci												
		23a. Part1. Enter	the disease, or co	mplications that caused	the death.				-		SVILLE	Approxi	
Pnysician		Immediate Cause disease or condition	(Final	ly one cause on each li		A. 1	STATES						nd Death
/Medical		resulting in death)	4	a Due to (or as			AWSI						
Examiner	_	Sequentially list co	onditions,	b. Due to (or as	1550		Ž.					ONE	224
ted nsit	Examiner	Sequentially list co if any, leading to in Cause (Disease or	mmediate edying r injury			_	EMIR	FRACTI	055	a d	MD .	NER .	~ .
e executed san and urial-transit	Exar	that initiated event resulting in death)	S	Due to (or as	a consequer		PORTOR	110-0011	19	wy/ all	MEDICAL EXAM	ONE	1344
ite be iysicia ne bur				La FALI					PANEL S	PPROVED BY		ONE	DAY
leath certificate be attending physici	Physician/Medical	IF FEMALE:							THE LEWIS TOWN			-	Total or to
aath ce attend for us	ian/	23b. Was deceder in the past 12	2 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal de	ath 3	Ectopic pregnand Other (specify)			2	3d. Date of de Month	livery Day	Year
that the de ed by the detached	ysic	1 ☐ Yes 2 9 ☐ Unknowr		9 Unknown	time or dout	5	_ Cities (specify) _						
The law requires that the death certificate be take been signed by the attending physicial page 2 should be detached for use as the bur	by Pł	Part II. Other signi	ificant conditions	contributing to death b	ut not resulti	ng in the u	inderlying cause gi	iven in Part I.	23e. Dio		se contribute t		
w require been sig should b		COUM	- لارهم	TOXICIT	4				1	Yes 2	SKNo 3⊟P	robably 4	□Unknown
e law r has be je 2 sh	Completed	CORC	MARY	AZTER	24	2772	ZASE		24a. Wa	is an opsy formed?	24b. Were a prior to	utopsy findir completion	ngs available of cause of
: The									1 ☐ Yes	2 Y No	death?	s 2☑No	
tending Physicien: The leath. for: After this certificate he the funeral director, page	o Be	25. Was case refe examiner? 1 ▼ Yes 2 □		Hospital: 1 ☑Inpatie	ant 2 TER	3/Outnatier	nt 3□ DOA Ct	26. Place of Dea ther: 4 Nursing H			S □Other (So	acifu)	
g Phy g Phy ier this	 	27. Manner of Dea	ıth	28a. Date of Inju (Month, Da		Bb. Time o			28d. Describe			Julyy	
ending F sath. or: After he funera	atlo	1 □Natural 2 ☑ Accident	5 ☐ Pending investigat	ion May 24	2005	6:00	AM 1]Yes 2. ANo	FALL				
or Att or Att or Att or Att or Att or Att	Certification:	3 Suicide 4 Homicide	determine	building, et	-	e, farm, sti	reet, factory, office		City or T	(Street and own, State)	d Number or F		Vumber, الاعام الدي
spitel ours a nerel i		29a. Certifier	1⊠ Certifying	Physician: To the best		edge, deat	h occurred at the t	ime, date and place			and manner a		MA
To the Hospitel or Attending Physicien: within 24 hours alter death. To the Funerel Director: After this certified completely filled in by the funeral director;	edical	(Check only one)		eminer: On the basis of and manner st	f examination								se(s)
To the within To the Comp	ž	29b. Signature and	d title of certifier	P			29c. Licen	ise number		29d. Date	e signed (Mon	th, Day, Yea	r)
		1	4	1 . M				,-000		w	4 25,	2005	
3		30. Name and add		6 completed cause of a		3а) (Туре, <u></u>		SPITAL	OF	BAL	TIMO	7 7	
Sta	ate	31. Date filed (Mo	nth, Day, Year)	32 Registr	rar's Signatur	Θ ,	4	عدر ا احد	Ur-	المساوي			
Registi		1	MAY 3 1 2	005	1 15.	ASSA	May 1						

			1 - For State Registrar	State of	f Marylan		artment of Hertificate of L		d Mental Hy	giene	05	18101
	Ш.	ig ig	1. Decedent's Name (First, Middle	e, Last)					2. Date of De	ath		3. Time of Death
	Physici /Medio		RACHEL	E. A	SHTON				MAY 11	, 2005	Year	11:35 PM™
	Examin		4a. Facility Name (If not institution	n, give street and num	nber)		4b. City, Town, or	Location of D	eath	4c. Co	unty of Death	
		2,	HCR MANOR HEAL!				BETHESD			MON	TGOMER	Y
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 X F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, Da	ay, Year)	Cou	olace (State or Foreign
10	Director		577-28-6259 Usual Residence of Decedent		84				1-29-	21	WASH	., DC
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Mar B-f st	tor	DC		WAS	SHINGT	ON					XXYes 2 □ No
	th the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	ntry?
	23s	rai	421 DECATUR S	TREET, N.	W.		200	11		U. S	. A.	
	ar des	Funerai	11. Marital Status	Armed For		.S. 13.	Was Decedent of His f Yes, specify Cubar	spanic Origin n, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	o- 14.	Race - Ameri Black, White,	
36	s afte	by F	1 ☐ Never Married 2 ☐ Marr 3 🛣 Widowed 4 ☐ Divorced		9		_ v	Specify:				ACK
215-0036	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or Items 23s or 28s-1 show ent, the Medical Erand, or must be molified at	ed k	15. Decedent		iles:	16a Decer	dent's Usual Occupa	tion		16h Kind	of Business/In	
5	n na n na	piet	(Specify only highes	st grade completed)		(Give	kind of work done di DO NOT use retired)	uring most of	working	TOD. KING	oi business/in	austry
212	with piene	Completed	Elementary/Secondary (0-12) 12TH GRADE	College (1	-40r 5+)		TYPIST			NAVY	ANNEX	
פ	be filed tal Hyg d othe avent,	Bec	17. Father's Name (First, Middle,	Last)				18. Mother's	Name (First, Middle			
ylaı	ould b Menta arked atic a	ToE	WILLIAM GEORG	E					AUDE BUCH.			
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If item 27 is marked other than "naturat", or items 23s or 28a-f show or other traumatic avent, the Medical Examinet must be indiffed in		19a. Informant's Name/Relationsi BRIAN FERGUSOI		ſ		g Address (Street a		r Rural Route Numb PASADEN			Code)
ē,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other otice.		20a. Method of Disposition			lace of Dispo	sition (Name of		Date		on - City or To	own, State
Baltimore,	Pages ent of nt: If i		1 X Burial 2 ☐ Cremation 1 Donation 5 ☐ Other (S)		state	-	natory`or other place IEMO. CEME		5-19-05	SUITL	AND	MD
alti	mit. I partm portal / inju		21. Signature of Funeral Service						PINCKNEY-			
m	Depared Depared Important in suny in posterior once.		Theodor	- Fine	kne		24 - 8TH S				DC 200	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca	used the date	n. Do not ent	er the mode of dying	, such as car	diac or respiratory a	rrest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	H		scler	who He	in	disea	ne		Onset and Death
	/Medical		resulting in death)	Due to (c	or as a consequ							
	Examiner		Sequentially list conditions,	ь. У.	Lena	1 te	culture					
	ad sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (d	or as a consequ		2 0011					
_	and I-tran	Examiner	that initiated events resulting in death) Last	c	or as a consequ	, ,	eson.		-			
8760	icate be executed physicien and s the burial-transit			Do		eral	vaecul	er c	Liseau	1		
387	icate phys s the	dicai		d	0,1,00		· · · · · · · · · · · · · · · · · · ·					
Вох	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	ome of pregna	ncy				234	Date of delive	200
ĕ	death a atter	cla	in the past 12 months?		nth 2 ☐ Fetal unt at time of de		Ectopic pregnancy Other (specify)			254.	Month	Day Year
o.	that the de led by the a detached f	hys	9 Unknown	9□ Unkno	wn							
ď.	res that igned I be det	ру Р	Part II. Other significant condition	ons contributing to de	ath but not resu	ulting in the ur	iderlying cause giver	n in Part I.	23e. Did t	obacco use c	contribute to th	ne cause of death?
ğ	w require been sig should b								_ 1 _ 1 _ `	Yes 2□N	o 3∏Prob	ably 4 Unknown
Records,	ie law requ has been je 2 shoul	Completed							24a. Was	an 24	b. Were auto	psy findings available inpletion of cause of
		E O				_			— autop perfo 1 ☐ Yes	rmed?	death?	
Vital	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?					26. Place of	Death (Check only o			
	Physic this o	ို	1 ☐ Yes 2 【XNo			EP/Outpatien	3 □ DOA Other	4 X Nursin	g Home 5 Resid	dence 6 🗆	Other (Specify	1)
n c	Jing P	on:	27. Manner of Death 1XXNatural 5 ☐ Pending	9	f Injury n, Day Year)	28b. Time of Injury	28c. Injury a Work?	?	28d. Describe f	now injury oc	curred	
Sic	tent feath tor: the	icat	2 Accident investig 3 Suicide 6 Could n	not be	of tailing. As to a			es 2 □No				
Division of	l or Attendation description of the Control of the	Certification;	4 Homicide determi	ined 286. Place of buildin	g, etc. (Specify	rne, rarm, stre	eet, factory, office		City or Tox	vn, State)	imber or Hura	l Route Number,
	spital ours nerel filled		29a. Certifier Certifying	g Physician: To the l	pest of my know	wledge death	occurred at the time	date and of	ace, and due to the	Calleg(e) and	manner as at	ated
	To the Hospital or At within 24 hours after or To the Funerel Direct completely filled in by	edical	(Check only one) Medical E	Examiner: On the bar and mann	sis of examinat	ion and/or inv	estigation, in my opi	nion, death o	ccurred at the time,	date and plac	ce, and due to	the cause(s)
	withir To th	Me	29b. Signature and title of certifier	2. not	1.		29c. License	number		29d. Date sig	ned (Month,	Day, Year)
			11/9	INCOR	25	· ·	Dog	253 1	591	5 -	-13-	25
	20		30. Name and address of person v									
	(4)		AJAY P. REDDY,				BLVD. BE	THESDA	, MD 2081	7		
1	Sta Registr	2.23	MAY 1 6 2003 (Year)	Bleeve 32. RA	gistrar's Gnat							

WHM			unpend i	Pleaso item#23a	Type or	Print in perME	Black G843,	Indelible In	k. Ensure A Health and I	All Copies	Are Le	gible.	10100
			1 - State Registrar		_			Certificate			Reg. No.	U 5	18102
	Physici /Medio		1. Decedent's Name		ast) rnathy			,		2. Date of Dea		Yeer	3. Time of Death 11:52 Ам
5	Examin		4a. Facility Name (I	If not institution, g		imber)		1	o, or Location of Deat CT HEIGHTS			unty of Death	EORGES CO
3105	Funeral Director		5. Social Security N	4169	Sex 1M 2□F	7. Age (In)	yrs. last birtho	Months Day		8. Date of Birt (Month, Da May 30	h y, Year) , 19	Col	nplace (State or Foreign untry) Sh.,DC
172	death with the Maryland ms 23a or 28a-1 show rmust be notified at	-	Usual Residence of 10a. State	10b. County			. City, Town o						10d. Inside City Limits 1 AYes 2 □ No
	th the M or 28a-f e notifi	Director	Md. 10e. Street and Nu		e Georg	ges .	Fores	tville 10f.Zip Code	9		10g. Citizer	of What Cou	
	s 23a o	ral	2100 Br	cooks D			- 11 0	2074				ed St	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 Is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic evant, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status 1 □ Never Marr 3 □ Widowed	ried 2XX Married 4 □ Divorced	Armed F	2 [X [No ive	n U.S.	If Yes, specify C	of Hispanic Origin? (S Juban, Mexican, Puerl No <i>Specify:</i>	pecity Yes or No- to Rican, etc.)	}	Race - Amer Black, White ecify: Bla	, etc.
2-00	72 hou natura	eted	(Spec	15. Decedent's cify only highest of	Education		16a. De	ecedent's Usual Oc	cupation ne during most of wo	rkina	16b. Kind	of Business/I	
Maryland 21215-0036	12 should be filed within 7. h and Mental Hygiene. 7 Is marked other than "n traumatic evant, "n. Medi	Completed	Elementary/Seco			1-4or 5+)	li	fe. DO NOT use ret	ontrol Sp		ct (Cover	nmont
d 2	filed v Hygie othar f	a	1 2 17. Father's Name	(First, Middle, La	st)		Mac	eriai co	-	me (First, Middle,		Govern	illienc
/lan	wuld be Menta arked aric ev	To B	Henry A	A. Aber	nathy S	Sr.			Lillie				
Mary	12 sho h and I		19a. Informant's Na Laura P			^	19b. M 139	lailing Address (Stre	enhouse S n, DC 2	iral Route Numbe	er, City or To W •	wn, State, Z	ip Code)
	Health Health tam 27		20a. Method of Dis		SISCEI		b. Place of D	shingtor isposition (Name of crematory or other p	1, DC 20) () 1 1 Date		ion - City or T	
E O	Pages nent of int: If i			Cremation 3 5 ☐ Other (Spec				dale Cre	l l	0/05	Rive	erdale	e, Md.
Baltimore,	permit. Departn Imports any inju		21. Signature of Fu	uneral Service Lic	ensee)		dress of Facility HC		Edwa	ards 1	F.H.
	0 0 = € O		23a, Party, Enter t	the disease, or co	CUQ molications that	caused the d			ver Hill			land,	Md.20746 Approximate
	Pnysician		shock, or hea Immediate Cause disease or condition	art failure. List on (Final	ly one cause on	each line.			scular Dis				Interval Between Onset and Death
	/Medical		resulting in death)		a		sequence of):	OCT COLOR					
	Examiner	<u></u>	Sequentially list co	onditions,	b. Due to	(or as a con	sequence of):						
	cuted id ansit	Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or that initiated events	injury	C								
90,	e be executed rsician and e burial-transit	ai Exa	resulting in death)	Last	Due to	(or as a con	sequence of):						
5876	certificate t iding physic				d								
Box 68760,	h certii ending use a	In/Me	IF FEMALE: 23b. Was deceden		23c. If yes, ou	itcome of pre		3 □Ectopic pregna	DOV		23d	Date of deliv	very
	wrequires that the death certificate been signed by the attending phy: should be detached for use as the	Physician/Medio	in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	□No		nant at time		5 ☐ Other (specify)				Month	Day Year
P.O	law requires that the as been signed by th 2 should be detache	by Ph	Part II. Dther signit		contributing to	leath but not	resulting in th	e underlying cause	given in Part I.	23e. Did to	obacco use	contribute to	the cause of death?
ords	equires en sig ould b	ed b	Cocaine	e Use						1 🗆 Y	′es 2□N	o 3□Pro	bably Dunknown
ecc	e 2 sh	Completed								24a. Was autop	SV	4b. Were aut	opsy findings available ompletion of cause of
al F	n: The ficate or, pag	e Cor	25. Was case refer	read to madical						Yes	rmed? 2 No	1 Yes	2×NO
ž.	ysiciai is certi directo	OB	examiner?		Hospital: 1	Inpatient 2	2 ☐ EP/Outpa	atient 3 DOA	Other	ath <i>(Check only o</i> llome 5 🗆 Resid		Other (Speci	(fy) SCENE
0	ing Ph Viter th	on: T	27. Manner of Deat	5 Pending		of Injury oth, Day Year	28b. Tim Inju	ry V	njury at Vork?	28d. Describe h			,, = ==================================
Division of Vital Records,	death ctor: A y the fu	ficat	2 Accident 3 Suicide	investigat	be 200 Bloo	e of Injury - A	At home, farm	M 1	☐ Yes 2 ☐ No	28f. Location (S	Street and N	umber or Rur	al Route Number,
Div	s after al Dire	Certification:	4 Homicide	determine	build	ling, etc. (Sp	ecify)	, 0.1001, 1401017, 01111		City or Tow			
	To the Hospital or Attanding Physician: The law within 24 hours after death. To tha Funaral Director: After this certificate has completely filled in by the funeral director, page 2.	edical (29a. Certifier (Check only one)	1☐ Certifying I 2X Medical Ex	aminer: On the b	pasis of exam	knowledge, d nination and/o	eath occurred at the investigation, in m	time, date and place y opinion, death occu	, and due to the d irred at the time, d	cause(s) and date and pla	manner as : ce, and due !	stated. to the cause(s)
	o the	Med	29b. Signature and	title of certifier	and mar	nner stated.		29c. Lice	ense number		29d. Date si	gned (Month,	Day, Year)
	- s + o			J	M	Jit		OCM		i		2, 200	
al.			30. Name and addr	ress of person An	o completed cau	se of death (Item 23a) (Ty	pe, Print) 111 Per	n Street	Baltimo	re. M	arvlan	d 21201
4	Sta	te	31. Date filed (Mon	nth, Day, Year)	22. I	Registrar's Si	ignature				,	ar y rain	
- 1	Registr		MΔ	Y 2 4 200	15		k A	2000					

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryla		artment of F		Mental Hy	/giene	05	18103
	Physici /Medic		1. Decedent's Name (First, Middle, Last Paula Athens					2. Date of D Month May 1	Day	Year	3. Time of Death 1:20 A
	Examir	ier	4a. Facility Name (If not institution, give Crescent City Cent		lder Ca		or Location of Dear rdale	th		nty of Death	eorges
	Funeral Director		5. Social Security Number 6. Se		s. last birthday)				rth ay, Year)	9. Birth	place (State or Foreign intry) Lfornia
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	cation		7.03/= 1/			10d. Inside City Limits
	Be-f sh	ector	MD Prince G	eorges H	yattsvi						1 t∏ Yes 2 □ No
	3a or 2	i Dire	10e. Street and Number 5800 39th Avenue			10f. Zip Code 20781			10g. Citizen o		intry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23e or 28e-f show minportant: If item 27 is marked other than "netural", or items 23e or 28e-f show my joilury or other traumatic event, the Medical Evantiant medical confiled at ODGE.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cub		Specify Yes or N to Rican, etc.)	U.S.A 14. R: Bi	ace - Ameri lack, White,	
21215-0036	n 72 ho "netur edical	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Deced	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wo	rking .	16b. Kind of		
212	d withi	Somp	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		ial Work			Hospi	ital	
Maryland	d be file	Be	17. Father's Name (First, Middle, Last) Pierre Athens				18. Mother's Na		, Maiden Suma	ame)	
aryl	should and Men s marke umatic	T _O	19a. Informant's Name/Relationship (7)	rpe, Print)	19b. Mailir	ng Address (Street	Martha and Number or R		er, City or Tow	n, State, Zij	p Code)
e,	1 and 2 Health a em 27 ls ither trai		Tracy L. Henry, Da		Place of Dispo	39th Ave		attsvill Date	e, Mary		
mor	Pages nent of the		1 ☐ Burial 2 📉 Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, cren	natory or other pla tan Crem	0 = 11	3/2005			Virginia
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service Licens		22	. Name and Addre	ss of Facility	Simple T	ribute		
			23a. Part1. Enter the disease, or complishock, or heart failure. List only o	ications that caused the de-						Maryl	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Parkinson'	s Disea						Onset and Death Years
B	Examiner			Due to (or as a conse	equence of):						
	ted nsit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):						
Ó,	cate be executed physician and the burial-transit	Exa		Due to (or as a conse	equence of):						
68760,	ficate b physic s the b	edica		1							
P.O. Box (The law requires that the death certificate be executed tte has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of preging 1 ☐ Live birth 2 ☐ Feregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnancy Other (specify)	/		1	ate of delive	ery Day Year
	quires that n signed by uld be deta	by	Part II. Dther significant conditions co Coronary Art.ery		esulting in the ur	nderlying cause giv	en in Part I.				he cause of death?
Division of Vital Records,		Completed						24a. Was auto perfo 1 Yes	ormed?	prior to cor death?	opsy findings available impletion of cause of
/ita	nysician: Th nis certificate director, pag	Be	25. Was case referred to medical examiner?	In an itali		100		ath (Check only	one)		
on of	S S	ion: To	27. Manner of Death 1 Xi Natural 5 Pending	lospital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	er: 4X Nursing ⊢ y at k? Yes 2 □ No		dence 6 Ot how injury occu		(y)
Division	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre lify)		163 2 3 100	28f. Location (City or To	Street and Num wn, State)	iber or Rura	al Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dirr completely filled in I	edical C	29a. Certifier 1 ☐ Certifying Phy: (Check only one) 2 ☐ Medical Exami	sician: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, death nation and/or inv	occurred at the tingestigation, in my o	πe, date and place pinion, death occu	, and due to the irred at the time,	cause(s) and m	nanner as st	tated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	· 1		29c. Licens	e number		29d. Date sign	ed (Month,	Day, Year)
			P Well de	umplated course of the first	- 00-1 (**	D2507	9		May 12	, 2005	5
			30. Name and address of person who co Dr. Yablonowitz, 2	404 Executive	e Place	•	, Marylan	d 20706			
	Sta Registr	te ar	31. Date filed (Month, Day, Year)	32. Figistrar's Sign							

		4	For State Registrar	State	e of Mary	and / Dep <i>Ce</i>	artmen rtificat			and M		giene ()	05	8 0 1:
	Physici		Decedent's Name (First, Mid							İ	2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Media	ai -	Wilson Keith 4a. Facility Name (If not institut		d number)		4h Ciby	Town or	Location of		MAY		2005 nty of Death	0519 M
	Examir	er	1		, ,	Contes	40. Oily,	alie	Location	/			ico mic	
	Funeral		Social Security Number	6. Sex	7. Age (In	yrs. last birthday,	If Under Months	1 Year Days	If Under:	24 Hrs.	8. Date of Birt (Month, Da) 5-25-5	h v Year)		place (State or Foreign ntry)
	Director		213-70-9678	1 X M 2□	F 47	Yrs.	WOTHERS	Days	Tiours	IVIII I.	5-25-5	7		Md.
	land	-	Usual Residence of Decedent 10a. State 10b. Cour	ity	100	. City, Town or L	ocation	.						10d. Inside City Limits
	r 28a-f show	to	Md. Word	ester	S	now Hil	L							14 Yes 2 □ No
	or 28g	irec	10e. Street and Number				10f. Zip	Code				10g. Citizen o	of What Cou	ntry?
	ath wi	Funeral Director	305 Park Row					1863				USA		
	ltems	nue	11. Marital Status 1 Never Married 2 M	Arme	Decedent Ever od Forces? res 2 No	in U.S. 13.	Was Deced If Yes, spec	dent of His city Cubar	spanic Ori n, Mexican	gin? (Spe n, Puerto	cify Yes or No Rican, etc.)	- 14. H	łace - Ameri Black, White,	
920	urs aft	by	3 ☐ Widowed 4 🎦 Divorce	If Ye	s, Give or Dates:		1 🗌 Yes	2NO	Specify:			Spe	city: Whi	ite
5-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "naturel", or Items 23a or 28a-f show ont, the Modical Exerting Instituted at	Completed		ent's Education hest grade comple	ted)	(Give	dent's Usua kind of wo	rk done d	luring most	t of worki	ng	16b. Kind of	Business/In	ndustry
121	within sne. than "	mpl	Elementary/Secondary (0-12		ge (1-4or 5+)	Sale	DO NOT u	se retired,)			Automo	tive F	Parts
9	be filed within tal Hygiene. d other than event, the M	ပိ	17. Father's Name (First, Midd			bar			18. Mothe	er's Name	(First, Middle,			
lan	ild be fental rked o	To Be	Lloyd A. Adkin	ns					Lura	Gord	dy Adki	ns		
Maryland 2121	2 should be filed withir and Mental Hygiene. Is marked other than eumetic event, Ins M		19a. Informant's Name/Relation	nship (Type, Print)	19b. Mail	ing Address	(Street a	ind Numbe	er or Rura	I Route Numbe	er, City or Tov	vn, State, Zij	Code)
	and 2 lealth m 27 I		Barbara A. Tr	ibeck, Si			Sirma				Hill, M			
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other treumetic en 2003.		20a. Method of Disposition 1 ☐ Burial 2 X Crematio			ob. Place of Disp cemetery, cre)ate	20c. Locatio		own, State
Itin	artmer ortant injury	1	4 □ Donation 5 □ Other21. Signature of Funeral Servi		10	remator	y OI I 2. Name ar		-		-03	Delmar	, De.	
Ba	Depin Impo) li	Active	et	*		Short	Fune	eral	Home	lmar, D	o 100	40	
			23a. Part1. Poter the disease, shock, or hear failure. L	or complications t	hat caused the								40	Approximate Interval Between
	Pnysician	i d	Immediate Cause (Final disease or condition	a	Can	liac	Grill	- 12	ma					Onset and Death
	/Medical Examiner		resulting in death)	Du	e to (or as a cor	nsequence of):	1. 1	-						-11/
		<u>-</u>	Sequentially list conditions, if any, leading to immediate	b. Du	e to (or as a cor	nyeguence of):	negy,	Ma						27 Mis.
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	1	(2)	come 1	Reel	Fa	relieu					Hims
o,	Attending Physicien: The law requires that the death certificate be executed rideath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.		resulting in death) Last	Di.	e to (or as a cor	nsequence of):	,	/	. 2	4	<i>y</i>			15.
8760,	icate be ex physician s the buria	dical		d		jakeke	/)2 <i>[1</i>]	neo z	rally	<u> </u>	- · · · -		10 413.
9 X	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If ye	s, outcome of pr	egnancy		-	- K.			23d	Date of deliv	erv
Box.	death e atter d for u	Physiclan/Med	in the past 12 months?	4 🗆 1	ive birth 2 🗌 Pregnant at time		□Ectopic p □ Other (sp					1	Month	Day Year
P.O.	at the de by the stached	hys	9 🗌 Unknown		Jnknown			-						
	ires fhat signed t d be det	by	Part II. Other significant cond	itions contributing	to death but no	t resulting in the	underlying d	ause give	en in Part I.			obaccouse c res 2 □ No		he cause of death?
orc	w requir been si should	Completed	- 2	1 0	asy 2	0 11	13 20/2.	,	2000		24a. Was			
Rec	he taw s has ge 2 :	ldw	Sever.	e Fer	pres		13 20/eu	· Q	1/132	ar.	autop perfo	rmed	prior to co death?	opsy findings available ompletion of cause of
tal	ysicien: The last certificate hadirector, page	a	25. Was case referred to med	ical	/				26. Place	of Death	1 Yes	22 No	1 🗌 Yes	2 No
Ž	nysici nis cer direc	To B	examiner? 1 ☐ Yes 2 Ø No	Hospital:	1 Inpatient	2 ER/Outpatie	nt 3 DC	Othe Othe			me 5 ☐ Resid		Other (Speci	fy)
Division of Vital Records,	ding Phys h. After this funeral di		27. Manner of Death 1 Natural 5 Pen		Date of Injury (Month, Day Yea	28b. Time (Injury		28c. Injury Work	at ?	P	28d. Describe i			
isio	death death stor: A	Certification:	3 Suicide 6 □ Cou	stigation Id not be	Place of Injunt	At home, farm, s	M treet factor		Yes 2□		28f Location /	Street and Nu	mber or Rur	al Route Number,
Dί<	after after Direct	ertif	4 Homicide dete		building, etc. (S		ireet, ractor	y, onice			City or Tov	vn, State)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	a. House Hamber,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certification (Check only one)	ying Physician: 1 al Examiner: On and	o the best of my the basis of exa manner stated.	/ knowledge, dea mination and/or i	th occurred nvestigation	at the tim	ne, date an pinion, dea	id place, a	and due to the ed at the time,	cause(s) and date and plac	manner as s	stated. to the cause(s)
	To the Within To the comple	Me	29b. Signature and title of cert			//	29	c. License	number			29d. Date sig	ned (Month,	Day, Year)
	-~		Benu	S O	· //	ain 14		0-	-20	03	D'	5	/11/6	35
	S.		30. Name and address of pers			(Item 23a) (Type	, Print)	1			2180		SCHERO	
	Car		BENITO CHAN A	10 1002	32. Red strar's S	Z St.	MI.	564	cy 1	nd	~180	1		
	Sta Regist	ite rar	31. Date filed (Month, Day, Ye	1 6 2005	Molera	Signature	South	ر'						

DHMH 17 Rev 1/2001

Wilson K. ADKINS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Yeer Physician May 10 10:00 A^M Brown 2005 Haro1d /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Capitol Heights 1524 Nova Avenue Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 XM 2 ☐ F 281-46-7991 Director March 11 1949 Alabama 56 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Madical Examiner must be notified at 1 X Yes 2 No Director Prince George's MD Capitol Heights 10e. Street and Number 10g. Citizen of What Country? U.S.A. 1524 Nova Avenue 20743 death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. be filed within 72 hours after d al Hygiene. d other than "natural", or Item 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Private 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, . Pages 1 and 2 should be fill timent of Health and Mental H tant: If Item 27 is marked off jury or other traumatic aven Be Louise Swain ၉ Milton Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14501 Delcastle Drive Bowie, Maryland 20721 Sheryl McRae/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 5/16/05 Riverdale, Maryland * 4 □Donation 5 □ Other (Specify) Riverdale Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. Jenkins Funeral Home oc. D. Ma 7474 Landover Road Landover, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final **Physician** Metastatic Colon Cancer resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physicien and s the burial-transit death certificate be executed Exami Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9□ Unknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 1 No 24a Was an certificate has tirector, page 2 s autopsy performed? Yes 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA this Director: After the 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Funeral 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Cartifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 2 D46591 May 13, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ndubuisi Achufusi M.D. 7940 Johnson Avenue Glenarden, Maryland 20706 31. Date filed (Month, Day, Year) Registrar's Signature State MAY 1 7 2005 Sperte Registrar

DHMH 17 Rev 1/2001

Physici /Medi Exami

Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28e-1 show any injury or other traumatic event. If a Medical Ever iter marker of the date once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Burford Gary Bailey Burford Gary Bailey	ime of Deat									
Secular Name of Process Institution of Process Institution of Secular Institution of Process Institution of Proc	20 P									
Non-service Social Service Number N										
So continued South										
Top Dear Top Dear De										
The State and Number 106. Emerged Code 106. Clipt, Town or Location 106. In Candover 106. Emerged Code 106. Clipt 106. Emerged Code 106.	<u>a</u>									
The Break and Number 10. Zip Code 10. Zip	side City Lin									
Type Continue Co	XYes 2□									
Type Continue Co										
Type Decided										
Type Decided	ian,									
16. Decaderity Education 16. Decaderity Education 16. Decaderity Usual Occupation 16. Kind of Businessindusin 16. Report Private 17. Minutes 16. Kind of Businessindusin 16. Monther's Name (First, Middle, Macker Sumame) 16. Monther's Nam										
Burford I. Bailey Sale Sa										
Burford I. Bailey Sale Sa										
Burford I. Bailey Sunforman's Name-Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cook Annie Railey/ Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cook Annie Railey/ Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cook Annie Railey/ Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cook Annie Railey/ Mother 20b. Repeated (Street and Number or Rural Route Number, City or Town, State, Zip Cook Annie Railey/ Mother 20b. Repeated (State) 20b.										
19s. Infantant's Name/Relationship (Type, Print) 19s. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2) Code Annie Bailey Mother 3206 81st Ave Landover, MD 20785 200. Method of Disposition 1										
19th Malling Address (Sirest and Number of Plural Route Number, City or Town, State, Zip Cook Annie Bailey Mother 3206 Method of Disposation 1 dispural 2 Command 3 Removal from State 200 Disposation 1 dispural 2 Command 3 Removal from State 200 Disposation 1 dispural 2 Command 2 2 2 2 2 2 2 2 2										
200. Delace of Disposition 1	1									
A Donation S Other (Specify) The (Sp	lata.									
22. Name and Address of Facility 3.6 Jenkins Funeral Home 7474 Landover, Mb 20785 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure, but only one cause of heart failure. 25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest. 25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 25a. Due to (or as a consequence of): 25a. Due to (or as a consequence of): 25a. Was diseased in pragnant in the part 12 months? 25a. Was diseased in pragnant in the part 12 months? 25a. Was diseased in pragnant in the of death 42 months? 25a. Date of delivery. 25a. Date of Death 12 months? 25b. Date of Death 12 months? 25b. Date of Death 12 months? 25c. Use of Death 12 months? 25c. Death 12 months? 25c. Death 12 months? 25c. Death 12 months? 25c. Death 12	ate									
23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. April Part P										
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Application of the control of the control of the cause (Final disease or condition resulting in death) 25a. Quentially list conditions, and of the cause (Final death) 25a. Quentially list conditions, cause. Enter Underlying cause (Disease or righty resulting in death) Last 25b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 25c. Was case referred to medical yearning? 25c.										
Due to (or as a consequence of):	oximate									
Due to (or as a consequence of): Due to (or as a consequence of):	ral Between It and Death									
Sequentially list conditions, a large property of the conditions across a consequence of): Sequentially list conditions are considered by the construction of the c										
Due to (or as a consequence of): Due to (or as a consequence of):										
Due to (or as a consequence of): Due to (or as a consequence of):										
IF FEMALE: 23c. It yes, outcome of pregnancy 1										
FFEMALE: 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 5 Other (specify) 2 Month Day Month										
FERMALE: 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 2 Month 2 Fetal death 4 Pregnant at time of death 9 Unknown 2 Month 2 Fetal death 4 Pregnant at time of death 9 Unknown 2 Month 2 Mon										
1 Yes 2 No 3 Probably										
1 Yes 2 No 3 Probably 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 25. Was case referred to medical examiner? 1 Yes 2 No 3 Probably 26. Place of Death (Check only one) 27. Manner of Death 1 Matural 5 Pending investigation 3 Suicide 4 Homicide 28a. Date of Injury At home, farm, street, factory, office 28t. Location (Street and Number or Rural Rouch Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Day, Day) 29d. Date signed (Month, Day, Day, Day)	Year									
24a. Was an autopsy prior to complete death 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 26. Place of Death (Check only one) 27. Manner of Death investigation 280. Describe how injury occurred 280. Describe how injur										
24a. Was an autopsy finder to complete death? 25. Was case referred to medical examiner? 1	se of death?									
24a. Was an autopsy performed? 24a. Was an autopsy performed? 1	4 XUnkno									
25. Was case referred to medical examiner? 1	dinos availa									
25. Was case referred to medical examiner? 1	on of cause									
examiner? 1	0									
27. Manner of Death 1 Manural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28c. Injury at Work? M 1 Yes 2 No 28d. Describe how injury occurred	avaminar?									
Solicide Could not be determined See. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Router of City or Town, State)										
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day,										
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day,										
(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the confidence one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, School of the confidence one) 29d. Date s	Number,									
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, 5/11/07	3 Number,									
1 June Ceurs 1250590 5/11/05										
	ause(s)									
THE STATE OF ACCUSES OF DRIVOT WITH COURSE OF GRAIN HIRM 2321 LIVER PORTS	ause(s)									
JONATHON A CALUE UD 7600 Carroll Ave Takoma Park, I	ause(s)									

1	+20			State of Maryland / Bak 27 per me G8					-	5	810		
		1- State Of Maryland, Department of Health and Per me G844 6 28 05 Las Italians Certificate of Death											
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	Year	3. Time of D	Death M	
	/Medic	al	George Alfred 4a. Facility Name (If not institution, give s			4h City Town or	Location of Death	May_	_	2005 ty of Death	2108		
4	Examin	ier	Anne Arundel Medi			Annapol		1		e Aru	nde1		
3	Funeral		5. Social Security Number 6. Sex		irthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth				Foreign	
9	Director		218-90-4852 ¹⁰³	M 2□F 35	Yrs.	Months Days	Hours Min.	May 23	1969	Mary	lace (State or F		
- 7	pu »		Usual Residence of Decedent 10a. State 10b. County	10c. City, Toy	am or Lo	ocation					0d. Inside City	Limite	
	shor	5	MD Anne Arun	,,		Crofton					1 □ XYes 2		
	28e-f	ect	10e. Street and Number	idei		10f. Zip Code			0g. Citizen of	What Cour	ntry?		
	3e or	ā	1852 Neumann Way			211	14		USA		,		
	within 72 hours after death with the Maryland ane. then "naturel", or Items 23e or 28e-f show hs Madical Examinar must be notified at	by Funeral Director		12. Was Decedent Ever in U.S.	13.	Was Decedent of Hi If Yes, specify Cuba		pecify Yes or No-	14. Ra	ice - Americ			
ဖွ	after or Ite	Ful	1 X Never Married 2 Married	Armed Forces? 1 ☐Yes 2 X No If Yes, Give		irres, specily cuba 1 □ Yes 2 🛣 No	Specify:	o nican, etc.)	Speci	ack, White,	etc.		
21215-0036	urel',	d b	3 Widowed 4 Divorced	Year or Dates:						WILL			
15-	"nat	Completed	15. Decedent's Educ (Specify only highest grade		a. Dece (Give life	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wor	king	16b. Kind of I	Business/in	dustry		
12	withii ene. then	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		ısician	,		Music	Indus	try		
9	Hygid other		17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,					
lan'	ould be filed with Mental Hygiene. arked other thei atic event, than	To Be	George A. Bold,	III			Donna N	Marie Ago	or				
Maryland	2 should and Men is marke eumatic		19a. Informant's Name/Relationship (Type	pe, Print) 19	b. Mailir	ng Address (Street a	and Number or Ru	ral Route Numbe	, City or Town	n, State, Zip	Code)		
	ss 1 and 2 should be filed within 72 hours after death with the Marylar of Heatih and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23e or 28e-f show then treumatic event, the Medical Examinar must be notified at		Donna M. Larman /		277	Neumann V	Way Cro	ofton, M					
Baltimore,	Pages 1 nent of H int: If Ite iry or oth		20a. Method of Disposition 1 ☐ Burial 2 M Cremation 3 ☐ R	emoval from State cemet	ery, crei	sition (Name of matory or other plac		Date	20c. Location	•			
Ħ	permit. Pa Departmen Importent: eny injury once.		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		-	Ltan Crema 2. Name and Addres					, VA.		
Ba	permit. Pages Department of I Importent: If Ite eny injury or of		21. Signature of Political Service Electris	*miell		512 NW Cra	DC	eall Fune Bowie		ome 20715			
1			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death. Do							Approximate Interval Betwe	əən	
	Physician		Immediate Cause (Final disease or condition	Complications							Onset and De	iath	
	/Medical Examiner		resulting in death)	Due to (or as a consequence									
	LAGIIIIICI	-	Sequentially list conditions,	Due to (or as a consequence	a of):							-	
	nsit	nlne	Sequentially list conditions, if any, leading to immediate class of injury that the conditions of the										
Ć,	that the death certificate be executed ed by the attending physician and detached for use as the buriat-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):										
760,	ysicia	cai											
89	ntifica ng ph as th	Med	IF FEMALE:										
Вох	ath ce ttendi or use	lan/I	23b. Was decedent pregnant in the past 12 months?	b. Was decedent pregnant in the past 13 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy						23d. Date of delivery Month Day Year		ar	
0	The law requires that the death certifica tie has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 L	Other (specify)					,		
Δ,	w requires that the been signed by the should be detach	þ	þ	Part II. Other significant conditions con	tributing to death but not resulting	in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use cor	ntribute to th	ne cause of dea	ath?
Records,	uires n sign lid be								1 🗆 Y	es 2 No	3 Prob	ably 4 Uni	known
CO	s bee	olete						24a. Was a		. Were auto	psy findings av	ailable	
Re	sicien: The law certificate has birector, page 2 s	Completed						autop: perfor 1 V Yes	ned?	prior to completion of cause of death? 1 Yes 2 No			
Vital				25. Was case referred to medical examiner?				26. Place of Dea	th (Check only or		~		
of V	Physicien: this certific ral director,	2	1 X'es 2 No Hospital: 1 XInpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursin						Home 5 ☐ Residence 6 ☐ Other (Specify)				
n o	on After	ion:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b.	te of Injury 28b. Time of 28c. Injury at Work? M 1 \[Yes 2 \] No				28d. Describe how injury occurred				
Division	l or Attending after death. Director; After I in by the fune	licat	2 Accident investigation 3 Suicide 6 Could not be				28f. Location (S	treet and Num	ber or Rura	ul Route Numbe	Θr.		
Σ	after Dire	Certification:	4 Homicide determined				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	To the Hospitel or Attent within 24 hours after death To the Funerel Director; completely filled in by the	edical C		sician: To the best of my knowledger: On the basis of examination a and manner stated.									
	To th within To th compl	Me	29b. Signature and title of certifier	,		29c. License	number	2	9d. Date sign	ed (Month,	Day, Year)		
	Hamele 45 outhall, mis					OCME M				May, 19, 2005			
2			30. Name and address of erson who co	mpleted cause of death (Item 23a HW, M)) (Type,		nn Chara	+ D=1++	one M	1 .	3 01001		
	Sta	ata	31. Date filed (Month, Day, Year)	Pegistraris Signature			nn Stree	L Baltim	ore Mai	ryrand	1 71701		
	Regist		MAY 2 5 2005	Slave M.	gre	le le							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1 - Stata Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Borman 2235 PV enneth 10 Ylaw 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner hester 101 P Centr If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. October 15,1918 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** NJ Country) Months 10XM 2□F 138-01-6688 86 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 27 is marked other than "netural", or items 23a or 28e-f show traumatic event, the Medical Exercit or must be notified at 1 ☐ Yes 2 No Director MD Chestertown Kent 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 10716 Mallard Point Road 21620 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □XYes, 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 is marked other than "netural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: þ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NQT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Chemica1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clara Ballman Ernest Borman 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Sternotti /granddaughter 23 Koenig Court, Fairlawn, NJ 07410 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 'Department of h 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Chesapeake Cremation May 13,2005 Stevensville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home, P.A.
130 Speer Road, Chestertown, MD 21620 21. Signature of Funeral Service License any is Auk 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician disease or condition resulting in death) /Medical e to (or as a consequence of) Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last muni Examiner The law requires that the death certificale be executed 6 Due to (or as a consequence of) the burial Box 68760. physician Physician/Medical as IF FEMALE 950 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ó in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 🗆 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has page 2 certificate 1 ☐ Yes Νo Hospitel or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 1 🗌 Yes 2 No npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 ☐ Other (Specify) this funeral ner of Death Time of 28d. Describe h After Certification: 1 Accident 5 Pending death. investigation Director: 3 🗀 Suicide 6 Could not be e, farm, street, factory, office 24 hours after on Funeral Direct 4 Homicide mo 29a. Certifier rifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due Medical Midical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) within 2 To the the 29c. License 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 2

Registrar
DHMH 17 Rev 1/2001

State

β0. Name and address of per

use of death (Item 23a) (Type, Print)

			State of Maryland / State Registrar	Department of Health and Mental Hygiene 0 5 8 0 9 Certificate of Death Reg. No.
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last) A. Facility Name (If not institution, give street and number)	2. Date of Death Month Day Year Moy 5 2005 2330 M 4b. City, Town, or Location of Death
	Funeral Director	C1	5. Social Security Number 6. Sex 7. Age (In yrs. last to 217-14-8803	Chester Acus Kert If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 8. Date of Birth Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland
	Maryland f show	tor		wn or Location 10d. Inside City Limits estertown 1 Tyes 1 No
	with the I te or 28a- 1 be multi	Director	100. Street and Number 10350 Fairlee Road	10f. Zip Code 10g. Citizen of What Country? 21620 USA
980	n 72 hours after death with the Maryland "natural", or Items 23e or 28e-f show ruical Exandrat must be multiped at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or Nofit Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	c * 5	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 th	a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School bus driver 16b. Kind of Business/Industry Kent County Bd. of Education
Maryland	S should be filed within and Mental Hygiene. is marked other then eumatic event. Its M	To Be (17. Father's Name (First, Middle, Last) Peter Sylvester Briscoe	18. Mother's Name (First, Middle, Maiden Sumame) Ida Washington
	54 ₹ 7 ± 7		Linda Briscoe (daughter)	3b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 480 Caulksfield Rd. Chestertown, MD 21620
Baltimore,	Page nent o ant: # ury or	2000	Burial 2 Cremation 3 Removal from State ASD	of Disposition (Name of early control of the place) of Church School of Maryland School of the place of the p
Balt	permit. Pag Department Importent: i any injury o		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Bennie Smith Funeral Home Chestertown MD
	Pnysician /Medical		resulting in death)	LITE CEREBRA INFARCTIONS Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, The any leading to inmediate. Due to for as a consequence.	
8760,	sate be executed obysician and the burial-transit	cal Examine	Sequentially list conditions, if any leading to him colatic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence consequence) c. Due to (or as a consequence consequence)	e of):
.O. Box 6	death certific e attending p d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death	th 3 Ectopic pregnancy 23d. Date of delivery 5 Other (specify) Month Day Year
rds, P	quires that n signed b	by	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 DUTK hown
al Records,	:: The law requires that the icate has been signed by th r, page 2 should be detache	Completed		24a. Was an autopsy findings available prior to completion of cause of death? 1 Ves 2 No 1 Ves 2 No
of Vital	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes	
Division o	ing Vftel	ertification:	1 Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	. Time of 28c. Injury at 28d. Describe how injury occurred Injury M 1 Tyes 2 No
Divis	- 9.5	Certific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospitel o within 24 hours aft To the Funerel Di completely filled in	edical		ge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
)	To the vithin To the comp	×	29b. Signature and title of certifier	29c, License number 29d. Date signed (Month, Day, Year) 5/9/05
			30. Name and address of person to completed cause of death (Item 23a) MICHAEL F. EMER W. 130	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 9 2005 32. Resistrar's Signature	* And

State of Maryland / Department of Health and Mental Hygiene 1 15

8		
707		-

Thredical Examiner 4e Fecility Neme (If not institution, give street end number) 7204 Leona Street 5. Social Security Number 240-68-2339 5. Social Security Number 240-68-2339 6. Sex 7. Age (In yrs. last birthday) 10c. City, Town or Localion 10a. State 10b. County 10c. City, Town or Localion 10c. City, Town or Localion 10c. City, Town or Localion 10d. Street end Number 10d. Street end Number 10d. Street end Number 10d. Street end Number 10d. Street end Number	11,2005 Peeth Ac. County of Deeth Prince George Signature of Birth Prince George Signature of Birth Prince George Signature of State of Foreign Country of Deeth Prince George 1 18,1944 North Carolina													
Leon Buffaloe May	11,2005 6:47PM Deeth Ac. County of Deeth Prince George (Birth Dey, Yeer) 9. Birthplace (Stete or Foreign Country) North Carolina 10d. Inside City Limits													
Funeral Director 4e Fecility Neme (If not institution, give street end number) 7204 Leona Street 5. Social Security Number 240-68-2339 6. Sex 50 M 2 F 61 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Days Hours Min. (Month Aprilement) 4b. City, Town, or Location of Expression of Express	Prince George (Birth Per, Yeer) 1 18,1944 Prince George 9. Birthplace (State or Foreign Country) North Carolina 10d. Inside City Limits													
Director 240-68-2339 \$\text{V} \text{ M} \text{ 2} \text{ F} \text{ 61} \text{ Yrs.} \text{ Months Days Hours Min. Apri} Usuat Residence of Decedent	1 18,1944 North Carolina 10d. Inside City Limits													
Q														
720/ Joops Street	10d. Inside City Limits 1 1 Yes 2 □ No 10g. Citizen of What Country?													
20747 Telest	USA													
11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 Never in U,S. Armed Forces. 1 Never in U,S. Armed Forces. 1 Never in U,S. A	r No-) 14. Race - American Indian, Black, White, etc. Specify: Black													
15. Decedent's Education (Specify only highest grede completed) (Specify only highest grede completed) (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry													
Elementery/Secondary (0-12) College (1-4or 5+) 12 Supervisor	U.S. Gov't.													
The latest willing address (Street and Number or Rurel Route Name (Route Name (Specify Control of Specify Co	·													
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route N Anita B. Buffaloe 7204 Leona St. Forestville,														
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 1 Donation 5 Other (Specify) 21. Signature of Funeral Service Liss e 22b. Place of Disposition (Name of cemetery, cremetory or other place) MD Veterans Cemetery 22c. Nama and Address of Fecility Cedar Hill	20c. Location - City or Town, State OD5 Cheltenham, MD													
21. Signature of Funeral Service Lives a 22. Nama and Address of Fecility Cedar Hill Fennsylvania Ave. Suitlar	1 Funeral Home,Inc.													
23s. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate shock, or heart failure. List only one cause on each line.	ry arrest, Approximate Interval Between Onset and Death													
Physician /Medical Immediate Cause (Finat disease or condition resulting in deeth) Examiner (Final disease or condition resulting in deeth) a. Cardio pulmonary arrest	Silser and Seath													
Due to (or as a consequence of):	isease or condition Call QLO PULLIFORARY AFFEST a.													
Sequentially tist conditions, if end of the liver Sequentially tist conditions, if end, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or as e consequence of): Due to (or as e consequence of): Due to (or as e consequence of):														
× se se di di di di di di di di di di di di di														
• 0 0 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 235.	Did tobacco use contribute to the cause of death?													
On the part of the	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 至 Unknown													
24a.	Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?													
Paga Paga Paga Paga Paga Paga Paga Paga	1 Yes 2 2 No 1 Yes 2 No													
25. Was case referred to medical examiner? 1 Yes 2 No														
C	Residence 6 □Other (Specify) ibe how injury occurred													
27. Menner of Deeth 1 Natural 2 Accident 3 Suicide 4 Homicide 4	on (Street and Number or Rural Route Number, Town, Stete)													
29a. Certifier 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to concern the concern to the concern that the time of the concern that t														
E E E B	29d. Date signed (Month, Day, Year)													
29c. License number D0010656	5/12/6													
29b. Signature end its of certains 29c. License number D0010656 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) 5530 Wisconsin Ave. Ste. 820 Chevy Chase, MD 20815	5/12/68													

			1 - For Stata Registrar	State of M	/larylan		artment <i>tificate</i>				_	iene	05	18111
	Physici	an	1. Decedent's Name (First, Middle, La.	st)							2. Date of Dea Month	Day	Year	3. Time of Death
	/Medi		-	len		Back	us				May 12	, 2005		12:11 a M
	Examir	ner	4a. Facility Name (If not institution, give		r)				Location of	of Oeath		4c. Count	y of Death	
			5305 Roosevelt	Street				thes)	ntgon	
	Funeral Director		304-07-1820	ex 7. A	85	last birthday) Yrs.	If Under 1	Days	If Under Hours	Min.	8. Date of Birth (Month, Day, March 7,	Year) 1920	9. Birth Cou I O	place (State or Foreign ntry) Wa
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c Cib	v. Town or Lo	cation							10d. Inside City Limits
	sho	ក		ntgomery	100.0.0	Beth								1 ☐ Yes 2 ☑ No
	28e-1	Director	10e. Street and Number				10f. Zip (Codo				0g. Citizen of	14/1-1-0-	
	d within 72 hours after death with the Maryland jiene. r then "neturel", or Itams 23a or 28e-1 show the Medical Examinan must be notified at		5305 Roosevelt	Street				2081	4		'	og. Citizen of	USA	nuy r
	death ms 2:	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.	S. 13. V	Was Decede	ent of Hi	spanic Ori	gin? (Spe	ecify Yes or No-	14. Ra		can Indian.
ပ္	or Ita		1 Never Married 2 Married	Armed Forces		i					ecify Yes or No- Rican, etc.)	Bla	ack, White,	etc.
03	ours a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates	:		⊺□ Yes 2	X No	Specify:			Speci	_{ty:} Whit	e
5-0	72 hc	Completed	15. Decedent's Ed (Specify only highest gra			16a. Deced	lent's Usual	Occupa	tion	t of worki	00	16b. Kind of E	Business/Ir	ndustry
21	iene. r then "	gu	Elementary/Secondary (0-12)	College (1-4o	r 5+)		kind of work DO NOT use				g			
12	filed w Hygier other tl		47 5-16-1-16-1-16-16-16-16-16-16-16-16-16-16	5+		Rese	arch S						dical	
Maryland 21215-0036	e = 5 ×	To Be	17. Father's Name (First, Middle, Last) Otto Carl Emil								(First, Middle, I . Verry	Maiden Suma	me)	
an	ss 1 and 2 should by Health and Ment item 27 is marked rother treumetic		19a. Informant's Name/Relationship (• • • • • • • • • • • • • • • • • • • •							l Route Number			
	and ealth n 27		Robert Coburn Bac	ckus/ Hus		-			t Str	eet,	Bethes	da, Ma	rylan	d 20814
Baltimore,	permit. Pages 1 a Department of Hea Importent: If item any injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		_ C6	lace of Dispo- emetery, cren opolitar	natory or oth	her place	9)	May	12,	20c. Location		
Ħ	artme prtent injury		*4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		, Lea				of Eacilit	200	_			Virginia
Ba	Depar Impo any ir	1 1/4	ru S.	Scerla	7	50	00 Uni	iver	sity	Blvd		lver S	Inc. pring	, MD 20901
			23a. Part . Enter the disease, or com shock, or heart failure. List only	olications that cause one cause on each	ed the death line.	n. Do not ente	er the mode	of dying	, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Corona	ry Art	tery D:	isease	.						Onset and Death
	/Medical Examiner	-	resulting in death)	Due to (or a	s a consequ	uence of):								
	LXdiffile		Sequentially list conditions,	b. Colon										
	asit sit	lne	Sequentially list conditions, if any, leading to immediate cause. First in any, is Cause (Disease or injury	ediate Due to (or as a consequence of):										
	and I-tran	Examiner	that initiated events resulting in death) Last	cDue to (or a	e a concecu	iance of\:	-							
8760,	death certificate be executed e attending physician and of or use as the buriat-transit	aE			o a concoqu	207100 01).								
687	ficate phys s the	edical		. d					-					
Вох	death certifica attending ph d for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom								23d Da	ate of delive	an/
m	death a atte d for	cla	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic pred Other (spec						onth	Day Year
0	that the de led by the a detached	hys	9 Unknown	9□ Unknown										
S, D	res tha igned l be det	by P	Part II. Other significant conditions of	ontributing to death	but not resu	ılting in the un	derlying car	use give	n in Part I.		23e. Did tob	acco use con	tribute to th	ne cause of death?
rd	w requires been sign should be										1 ☐ Ye	s 2 🖺 No	3 Prob	ably 4 Unknown
Vital Record	aw Is b	Completed									24a. Was ar	24b.	Were auto	psy findings available
Ř	0 L 0	mo									autopsy perform	red?	death?	mpletion of cause of 2□ No
ita	icien: Th certificate rector, pag	0	25. Was case referred to medical						26. Place	of Death	Check onl one		1 0 103	2 140
Į <	d is	To B	examiner? 1 ☐ Yes 2(X No	Hospital: 1 ☐ Inpat	ient 2 🗆 E	ER/Outpatient	3 DOA				ne 5 🔀 Reside		ner (Specif	iv)
	ng Pt Iter th		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury av Year)	28b. Time of Injury	28	c. Injury Work	at	2	8d. Describe ho	w injury occur	red	
Sio	Attending r death. sctor: After by the fune	atle	2 Accident investigation				М		es 2 🗆 N	No				
	I or Attending Ph after death. Director: After th I in by the funeral	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of in	njury - At hor tc. (Specify	me, farm, stre	et, factory,	office		2	8f. Location (Str. City or Town		ber or Rura	l Route Number,
	urs af urs af urel D			i										
	To the Hospital or At within 24 hours after d To the Funerel Direct completely filled in by	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the bes iner: On the basis and manners	of examinati	wledge, death ion and/or inv	occurred at estigation, in	t the time n my opi	e, date and nion, deat	d place, a h occurre	and due to the ca ad at the time, da	use(s) and ma te and place,	anner as st and due to	tated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c.	License	number		29	d. Date signe	ed (Month,	Day, Year)
			$\lambda_{\Lambda\Lambda\Lambda}$	XIXIA	1				H51	280		May	12,	2005
	18		30. Name and address of person who	completed cause of	death (Item	23a) (Type, F	Print)							
			Anushiravan Dadga				219 Ex	ecut	ive	Park	Terr.,	German	ntown	, MD 20874
**	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 3	2005 32. He ist	rar's Signati	L. A	porte	>						

	ld Lane		Unpend iten#3 1- State Registrar				te of Death		Rag. No.	CU	10116
	Physici		1. Decedent's Name (First, Middle, La Donald Lane Bur	,				2. Date of D Month	Day	Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, given	ve street and number))		, Town, or Location of		-	unty of Death	3:56 P ^M
E	Francis		6390 Crain Highwa	-	ge (In yrs. last bin		lata erlYear If Under 2	24 Hrs. 8. Date of B	Char		place (State or Foreign
100	Funeral Director			1 X M 2□F		Yrs. Months		Min. (Month,) Feb. 2	1958	Wash	intry)
4)	Maryland -f ahow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Location					10d. Inside City Limits
	r 28a-f ahow	Director	Maryland Charles 10e. Street and Number		LaPlata		0.4		40 011		X☐Yes 2☐No
	within 72 hours after death with the ene. than "natural", or Itams 23a or 28a he Medical Examiner must be rical	al Dir	6390 Crain Highw	ay			p Code 0646		10g. Citizen Unite	orwnat Cou d Stat	•
10	rurs after death with al', or Itams 23a or Examine munt Le	Funeral	11. Marital Status 1 ☑Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 \(\text{Yes} \) 2 \(\text{A}	Ever in U.S.	13. Was Dece If Yes, spe	edent of Hispanic Orig ecify Cuban, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	14.	Race - Ameri Black, White	
3036	ours af IEram	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2XNo Specify:			cify: rican	American
715-(in 72 hours n "natural", Vedical Ex	Completed	15. Decedent's E (Specify only highest gr	ade completed)		Decedent's Usu (Give kind of we life. DO NOT to	ual Occupation ork done during most use retired)	of working	16b. Kind o	f Business/Ir	ndustry
212	ygiene ygiene yar thai	Com	Elementary/Secondary (0-12)	College (1-4or !		Auto Med	chanic			notive	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturany injury or other traumatic avant, the Medical once.	To Be	17. Father's Name (First, Middle, Last Sterling A. Burt	•				's Name <i>(First, Middl</i> dred June			
lary	2 shou and M is mar raumat	-	19a. Informant's Name/Relationship (s (Street and Number				
ē,	Health tam 27		Mildred J. Burto		20b. Place of	Disposition (Na	Eagle Terra	ace, Inver		FL 34 on - City or To	
Baltimore,	Pages ment of ant: # i		1 ☐ Burial 2 【XCremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Special			y, crematory or peake Cr		5/20/05	Belts		
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Lice	nsee			nd Address of Facility Seorgia Av				
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	oplications that caused	the death. Don						
	Priysician /Medical		Immediate Cause (Final		110.		de or dyrig, such as c	ardiac or respiratory	arrest,		Approximate Interval Between
			disease or condition resulting in death)	A CONTRACTOR OF THE PARTY OF TH	rnia con	plicati				ascul	Approximate Interval Between Onset and Death ar disease
	Examiner		resulting in death)	A CONTRACTOR OF THE PARTY OF TH		plicati				ascul:	Interval Between Onset and Death
	Examiner	miner	resulting in death) Sequentially list conditions, any leading to incrediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	rnia con	plicati				ascul:	Interval Between Onset and Death
90,	Examiner	Examin		b. Due to (or as	rnia com a consequence o	plicati of):				ascul:	Interval Between Onset and Death
68760,	Examiner	Examin	Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	mia con a consequence o	plicati of):				ascul	Interval Between Onset and Death
30x 68760,	Examiner	Examin	Sequentially list conditions, any leading to incrediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	b. Due to (or as c	a consequence of a consequence of of pregnancy	plicati of): of):	ng atheros		cardiov	Date of delive	Interval Batween Onset and Death ar disease
Вох	ath certificate be executed xaranticate be executed xaranticate burial-transit unit of the burial-transit and the burial-transit and the burial-transit and the burial-transit and the burial-transit and the burial-transit	Examin	resulting in death) Sequentially list conditions, any leading to innectiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as c	a consequence of a consequence of pregnancy 2 ☐ Fetal death	plicati of): of):	ng atheros		cardiov		Interval Batween Onset and Death ar disease
P.O. Box	se that the death certificate be executed as gned by the attending physician and be detached for use as the burial-transit	Physiclan/Medical Examin	resulting in death) Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	Due to (or as b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	a consequence of a consequence of oregnancy 2 Fetal death time of death	plicati of): of): 3 Ectopic p 5 Other (sp	regnancy	sclerotic	cardiov	Date of deliver	Interval Batween Onset and Death ar disease
P.O. Box	requires that the death certificate be executed by the attending physician and mould be detached for use as the burial-transit	by Physiclan/Medical Examin	Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	a consequence of a consequence of oregnancy 2 Fetal death time of death	plicati of): of): 3 Ectopic p 5 Other (sp	regnancy	23e. Did	23d. tobacco use co	Date of deliver Month ontribute to the	ery Day Year Dably 4 NUnknown
P.O. Box	Taw requires that the death certificate be executed by the attending physician and be should be detached for use as the burial-transit because the contraction of the	by Physiclan/Medical Examin	Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	a consequence of a consequence of oregnancy 2 Fetal death time of death	plicati of): of): 3 Ectopic p 5 Other (sp	regnancy	23e. Did	23d.	Date of deliver Month ontribute to the state of the stat	ery Day Year he cause of death? pably 4 XUnknown psy findings available mpletion of cause of
P.O. Box	Taw requires that the death certificate be executed by the attending physician and be should be detached for use as the burial-transit because the contraction of the	Be Completed by Physiclan/Medical Examin	resulting in death) Sequentially list conditions, any leading to innect at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the conditions of the cause of the conditions of the cause	Due to (or as b	a consequence of a consequence of pregnancy 2 Fetal death at time of death at not resulting in	plicati of): 3 Ectopic p 5 Other (sp	regnancy pecify) cause given in Part I.	23e. Did	23d. tobacco use co Yes 2 \(\text{No} \) s an 24 psy pormed? 2 \(\text{No} \)	Date of deliver Month ontribute to the state of the stat	ery Day Year Dably 4 XUnknown Daysy findings available
P.O. Box	Physician: The law requires that the death certificate be executed the third certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burial-transit	To Be Completed by Physiclan/Medical Examin	resulting in death) Sequentially list conditions, any Leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of examiner? 1 X Yes 2 No 27. Manner of Death	Due to (or as b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown contributing to death b	a consequence of a consequence of pregnancy 2 Fetal death time of death at not resulting in	plicati of): 3 Ectopic p 5 Other (sp the underlying of	regnancy pecify) cause given in Part I. 26. Place of the cause of th	23e. Did 1	cardiov 23d. tobacco use co Yes 2 \(\text{No} \) s an appropriate (2 \(\text{No} \) one) idence (\(\text{Cor} \)	Date of deliver Month ontribute to the series of the confider	eny Day Year he cause of death? pably 4 DUnknown psy findings available mpletion of cause of 2 No y) Scene
P.O. Box	Affige Physician: The law requires that the death certificate be executed to the first fir	To Be Completed by Physiclan/Medical Examin	Sequentially list conditions. In y leading to in restals cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown contributing to death b	a consequence of a consequence of pregnancy 2 Fetal death time of death ut not resulting in	plicati of): 3 Ectopic p 5 Other (sp the underlying of njury 50 PM	regnancy pecify) 26. Place of the control of the c	23e. Did 1 24a. Was auto performed to the control of Death Check only sing Home 5 Res 28d. Describe Control of	23d. tobacco use co Yes 2 No s an psy ormed? 24 No one) idence SAC how injury occ the same of the sa	Date of delivered Month Description of the Control	ery Day Year Dably 4 Munknown psy findings available mpletion of cause of 2 No y) Scene
of Vital Records, P.O. Box	Affige Physician: The law requires that the death certificate be executed to the first fir	To Be Completed by Physiclan/Medical Examin	resulting in death) Sequentially list conditions, Tany, leading to innered at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown contributing to death b Hospital: 1 Inpatie 4 Inpatie 5 -5 -05 28e. Place of Injuniting to general and the second sec	a consequence of a consequence of of pregnancy 2 Fetal death time of death ut not resulting in a consequence of pregnancy 2 Fetal death time of death time of death of the consequence o	plicati of): 3 Ectopic p 5 Other (s) the underlying of ime of injury m, street, factor	regnancy pecify) 26. Place of the control of the c	23e. Did 1 1 24a. Was autopent De Yes of Death Check only sing Home 5 Res 28d. Describe 28d. Describe City or To	tobacco use or Yes 2 No No No No No No No No No No No No No	Date of deliver Month Description of the control o	ery Day Year Day Year Dably 4 Munknown Day findings available mpletion of cause of 2 No Day Scene
P.O. Box	Hospital or Attanding Physician: The law requires that the death certificate be executed XA hours after death. Eunaral Director: Itel this certificate has been signed by the attending physician and Itely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Certification: To Be Completed by Physician/Medical Examin	Sequentially list conditions. I any leading to investigate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown contributing to death b Hospital: 1 Inpatie The late of Injunction of the basis of	a consequence of a consequence of pregnancy 2 Fetal death time of death ut not resulting in 3: and 2 ER/Out Ty Year In 3: and 2 ER/Out Ty Year In 3: and 3 ER/Out Ty Ye	plicati of): 3 Ectopic p 5 Other (sp the underlying of ime of njury m, street, factor	regnancy pecify) cause given in Part I. 26. Place of the second work? 1 Yes 2 XNo. 27. And the time date and the tim	23e. Did 1 24a. Was autoperfit 22 Yes of Death Check only sing Home 5 Res 28d. Describe 28d. Describe City or To LaPla	tobacco use converse 2 No No No No No No No No No No No No No	Date of delivered Month Description to co death? Description to co d	ery Day Year Day Houle Number, All Route Number, All Hay
P.O. Box	or Attanding Physician: The law requires that the death certificate be executed the death certificate be executed to be the death care of the this certificate has been signed by the attending physician and bin by the funeral director, page 2 should be detached for use as the burial-transit.	To Be Completed by Physiclan/Medical Examin	resulting in death) Sequentially list conditions. Tany leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown contributing to death b The late of Injundenth, Day 1 Se. Place of Injunding, etc found	a consequence of a consequence of pregnancy 2 Fetal death time of death ut not resulting in 3: and 2 ER/Out Ty Year In 3: and 2 ER/Out Ty Year In 3: and 3 ER/Out Ty Ye	plicati of): 3 Ectopic p 5 Other (s) the underlying of sime of signey m, street, factor set death occurred door investigation	regnancy pecify) cause given in Part I. 26. Place of the second work? 1 Yes 2 XNo. 27. And the time date and the tim	23e. Did 1 24a. Was autoperfit 22 Yes of Death Check only sing Home 5 Res 28d. Describe 28d. Describe City or To LaPla	tobacco use converse 2 No No No No No No No No No No No No No	Date of delivered Month Description of the Control	ery Day Year Day Year Day Year Day Year Day Year Day Year Day Scene Cold Col
P.O. Box	Hospital or Attanding Physician: The law requires that the death certificate be executed XA hours after death. Eunaral Director: Itel this certificate has been signed by the attending physician and Itely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Certification: To Be Completed by Physician/Medical Examin	resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown contributing to death b Hospital: 1 Inpatie Philate of Inju (Month, Da) 5-5-05 28e. Place of Inju building, et found hysician: To the bast of and manner sta	a consequence of a consequence of pregnancy 2 Fetal death at time of death	plicati of): 3 Ectopic p 5 Other (s) the underlying of ime of njury 50 PM rm, street, factor et	regnancy pecify) 26. Place of the control of the c	23e. Did 1 24a. Was autoperfit 22 Yes of Death Check only sing Home 5 Res 28d. Describe 28d. Describe City or To LaPla	tobacco use converged to the converged t	Date of delivered Month Description of the Control	ery Day Year Day Year he cause of death? pably 4 DUnknown psy findings available mpletion of cause of 2 No y) Scene cold froute Number, ain Hwy tated. the cause(s) Day, Year)
P.O. Box	Hospital or Attanding Physician: The law requires that the death certificate be executed XA hours after death. Eunaral Director: Itel this certificate has been signed by the attending physician and Itely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Certification: To Be Completed by Physician/Medical Examin	resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown contributing to death b Hospital: 1 Inpatie Philate of Inju (Month, Da) 5-5-05 28e. Place of Inju building, et found hysician: To the bast of and manner sta	a consequence of a consequence of pregnancy 2 Fetal death at time of death	ipalicati of): 3 Ectopic p 5 Other (sp the underlying of the un	regnancy pecify) 26. Place of the place of	23e. Did 1	tobacco use converse 2 No san 24 No	Date of deliver Month Description of the Control o	ery Tear disease Day Year Day Year Day 4 EUnknown Day 5 CODE Cold

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 5-30 AM May 2005 Sadie B. Bennett 13, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Salisbury Wicomico 5792 Homestead Lane If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Days Hours 1 □ M 2 🗓 F 213-22-7083 Director 7-16-27 DE. Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f ahow the Medical Examiner must be notified at Director 1 ☐ Yes X☐ No Salisbury Md. Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5792 Homestead Lane 21801 USA or Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after Copartment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or fler any injury or other traumatic event, the Meutical Examine 2008. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jack Cooper Clementine Boyce 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5804 Greenwood St. Salisbury, Md. 21801 Mary Jo Perry, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Galestown Cemetery Seaford, De. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC CARCINOMA OF **Physician** disease or condition resulting in death) 3 YEARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician ar Due to (or as a consequence of): Box 68760 Physician/Medicai as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. I by the a 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Deen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe certificate has irector, page 2 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) ٥ 1 Yes 2 No 2 ER/Outpatient 3 DOA funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred After 1 Matural 5 Pending investigation after death. 2 🗆 No 1 🗌 Yes 2 Accident the 6 Could not be 3 🗌 Suicide in by t 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Hospital Filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D46962 MAY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. SHIRAZI, M.D. 31575 WINTER PLACE PARKWAY. SALISBURY. MD21804 31. Date filed (Month, Day, Year) State Genera & Sparke

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

05-3301 Corey Broadnax

			State of Maryland / Department 1- State of Maryland / Department 1 per me G844 6-9-05 conflicate	of Health and M of Death		ienje 005 1811	1,
ı	Physici	ian	Decedent's Name (First, Middle, Last) Corey Andrea Broadnax		2. Date of Death Month May	Day Year	
	/Medi Examir		4a. Facility Name (If not institution, give street and number) 4b. City, To	own, or Location of Death	May	12, 2005 10:53	A ^M
1	LXamii	101		ltimore		Baltimore City	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birthplace (State or Fo	reign
	Director		429-51-4732 Print 2 F 22 Yrs. Moritins Usual Residence of Decedent		Dec. 14,	1982 Arkansas	
	yland how		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Li	imits
	Be-1 e	Director	Maryland Wicomico Salisbury			1 [X Yes 2] No
	with the		10e. Street and Number 10f. Zip C		10	g. Citizen of What Country?	
	ns 23	eral		1801 nt of Hispanic Origin? (Spi	ecity Ves or No.	USA 14. Race - American Indian,	
9	or Iter	by Funeral	Armed Forces? If Yes, specify 1 ★Never Married 2 ★Married 1 ★Yes 2 ★No	y Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.	
21215-0036	within 72 hours after death with the Maryland ene. than "netural", or Items 23s or 28e-f ehow the Modigal Examinat must be notified at	d by	3 Wildowed 4 Divorced Year or Dates:	☑ No Specify:		Specify: Black	
-51:	in 72 n "net	Completed	(IFA 1)(1)(1) USA	done during most of work	ing 1	6b. Kind of Business/Industry	
212	d with giene.	mo	Elementary/Secondary (0·12) 11th College (1-4or 5+) laborer		I	Delivery Service	
pu	nould be filed within 1 Mental Hygiene. narked other than " netic event, INE Wat	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, M	aiden Sumame)	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 le marked other than "netural", or items 23s or 28e-1 ehow other traumetic event, the Modical Examinar must be notified at	2	George Jovan Broadnax 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (S		Marie Wi		
	nd 2 shoulth and 1					City or Town, State, Zip Code) Maryland 21801	
altimore,	of Health of Health Iltem 27 I		20a. Method of Disposition 20b. Place of Disposition (Name	of [Oc. Location - City or Town, State	-
Ē	Page ment ent: If ury or		'4 □ Donation 5 □ Other (Specify) Springhill Mem.	Gdns 05/18	8/2005 H	ebron, Maryland	
Ball	permit. Pages in Department of Hamportent: If Ite eny injury or ot once.			Address of Facility 121	3 Jersey	Road - Salisbury, M	i D
				MEMORIAL (21801	1
	e Poysician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.	The second second		2	i h
	/Medical		disease or condition resulting in death) a	910135 0	rith (on	pucations	
	Examiner	_	Sequentially list conditions, b.				
V	nsit	Examine	if any, leading to immediate cause. Enter Underlying Cause, Disease or injury				
oʻ	execu an and rial-tra		that initiated events c				
8760,	icate be executed physician and s the burial-transit	dical	d				
9 ×	leath certific attending p	/Мес	IF FEMALE: 23b. Was decedent prognant 23c. If yes, outcome of pregnancy				
Вох	death certifu e attending d for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23b. If yes, outcome of pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (speci	nancy ifv)		23d. Date of delivery Month Day Year	
0	the che	hysi	9 Unknown 9 Unknown	·/-			
S,		by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	se given in Part I.	23e. Did toba	cco use contribute to the cause of death?	7
orc	law requires as been sign 2 should be	eted			1 Tes	3 No 3 Probably 4 □Unkno	own
Records,	9 4 9	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause death?	
	(0 T	0	25. Was case referred to medical	26. Place of Death	Yes 2	□ No 12 Yes 2 □ No	
of Vi	8 0 =	To B	examiner? 1 XYes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other	ne 5 Residen	ce 6 ☐Other (Specify)	-
			27. Manner of Death 28a. Inte of Injury 28b. Time of 28c.	Work?	28d. Describe how		
Division	Attending r death. sctor: After by the fune	flcat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. lace of injury. At home, farm, street, factory, o	1 Yes 2 No	Set Location Arra	et apd Number or Rural Route Number.	
<u>S</u>	el or A s after of in b	Certification:	4 Momicide determined building, etc. (Specify)	Tice /		State TST 716 81	
	To the Hospitel or Attenowithin 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only (Check only note)) 1 Certifying Physician: To the best of my knowledge, death occurred at the control of the basis of examination and/or investigation, in	he time, date and place, a	and due to the cau	se(s) and manner as stated.	
	To the h within 24 To the F complete	Medi	and masner stated.				
	T W T	_	290.	OCME		ay 13, 2005	
		-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			,	
	5		J. CARON COURS, MD 111	Penn Stree	t Balti	more, Maryland 2120)1
	Star Registra		31. Date filed (Month, Carana 1 2005 32. Refistrar's Signature)	,			

			For State Registrar	State of M	aryland		artmen <i>tificat</i>			ind Me		iene g. No.	005	18115
			Decedent's Name (First, Middle, La.	st)							2. Date of Dea Month	th Day	Year	3. Time of Death
	Physicia /Medic		GEORGER CHASE	JR.							5	12	2005	6:00 AM
7	Examin		4a. Facility Name (If not institution, give	street and number)					Location o	f Death	3	4c. Co		Prince
			BRADFORD UTIKS					LINTO		2411				eorges
	Funeral		5. Social Security Number 6. S	ex 7. Ag	pe (In yrs. Ia	st birthday) Yrs.	Months	1 Year Days	Hours 1	Min.	B. Date of Birth (Month, Day	Year)	Cou	place (State or Foreign htry) yland
	Director		216 - 22 - 28 26 1 Usual Residence of Decedent	7	7.7						10 - 08	-1927	Flat	yrand
	land ow		10a. State 10b. County		10c. City,	Town or Lo	cation						1	10d. Inside City Limits
	Mary -1 sh	ţ	Maryland Charl	.es		Brya	ntow	n						Yes 2 No
	r 28a	Director	10e. Street and Number				10f. Zip				1	0g. Citizer	of What Cou	ntry?
	23a o		P.O.BOx 81-1263	8 LaPlat	ta Ro	ad		20	617			US	A	
	ens ens	ner	11. Marital Status	12. Was Decedent Armed Forces		3. 13.	Was Dece f Yes, spe	dent of His	spanic Orig	gin? (Spec , Puerto P	city Yes or No- tican, etc.)	14.	Race - Americ Black, White,	
36	or It	by Funeral	1 Never Married 2 Married	1 □ Yes 2 1 If Yes, Give	No		1 🗆 Yes	2 X No	Specity:			Sp	Blac	- k
5-0036	72 hours after death with the Maryland 'natural', or Items 23e or 28e-1 show dical Exercit or most be rediffed at	d b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		16a. Dece	dent's Usu	al Occupa	tion				of Business/In	
15	n 72 n "na	Completed	(Specify only highest gra	de completed)		(Give	kind of wo	rk done d	uring most	of workin	g	TOD. TUNG	0. 000000	
2121	filed within Hygiene.	E O	Elementary/Secondary (0-12)	College (1-4or	5+)	Sto	ck C	lerk			F	eder	al Go	vernment
b	Hygi other	BeC	17. Father's Name (First, Middle, Last						18. Mothe	r's Name	(First, Middle,	Maiden Su	ımame)	
<u>lar</u>	Mental Mental Mrked o	To B	George R. Chas	e Sr.					Mary	L.	Middl	eton		
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Me		19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address	s (Street a	nd Numbe	r or Rural	Route Number O. Box	City or To	own, State, Zip	Code)
	and 2 ealth m 27 her tra		Mary H. Chase-	Wife		1263	B La	<u>Plat</u>	a Rd	, Bry	yantow	n Ma	ryland	20617
ore	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan cardinent of Health and Menial Hygiene. ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examinat must be notified at injury or other traumatic event, the Medical Examinat must be notified at a.		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □	Removal from State	CA	ace of Dispo metery, crer	natory or o	me of other place	9)	Da	ate	20c. Local	tion - City or To	own, State
Ë	Pagiment ment:		' 4 ☐ Donation 5 ☐ Other (Special	y)							-05	Brya	ntown	Maryland
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr QDGs.		21. Signature of Funeral Service Lice	2	19				s of Facility eral	•	nePA,A	quas	co MD	20608
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each !	ine						respiratory arr	est,		Approximate Interval Between
2	Physician		Immediate Cause (Final disease or condition	· ARTERI	u scl	profic	Hen	wt	oise	me				Onset and Death
	/Medical		resulting in death)	Due to (or a	s a consequ	ence of):								
K	Examiner	_	Sequentially list conditions,	b. Due to (or as		anna off:								
	ed isit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	erice oi).								
	xecul and al-trar	Examiner	that initiated events resulting in death) Last	C. Due to (or as	s a consequ	ence of):								
8760,	ate be executed hysician and the burial-transit	dical		d										
9		edic												
Box	that the death certific ed by the attending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom-	e of pregnar		∃Ectopic p	regnancy				230	d. Date of deliv Month	
	death ed for u	sicle	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant a			Other (s						MOULU	Day Year
P.0	that the ed by th detache	Phy	9 Unknown			***					ana Did to	haasa usa	contributo to t	he cause of death?
	es De	by	Part II. Other significant conditions	contributing to death	bui not resu	iting in the u	naeriying i	cause give	n in Part I.					
ord	w requires been sign should be	ted												
ec	2 8 8	Completed									24a. Was a autop: perfor	SV	prior to co death?	opsy findings available impletion of cause of
Vital Records,	ale ale										1 ☐ Yes	2 No	1 Yes	2 □ No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only or	-	70	
ō		- T	1 Yes 2 No	28a. Date of Ing (Month, D		ER/Outpatier 28b. Time o		28c. Injury Work	4 C NU		ne 5 Resid			(y)
on	ding f th. After funer	tion	1 Natural 5 Pending 2 Accident investigation		ay Year)	Injury	М		:? ∕es 2 🔲 I	No				
Division of	Atten dea octor	Certification:	3 ☐ Suicide 6 ☐ Could not b	e Ope Place of I	njury - At hor	me, farm, st	reet, factor	ry, office		2	Bf. Location (S City or Tow	treet and N	Number or Run	al Route Number,
Ö	al or	Sert	4 Homicide	building, e	nc. (Specify)					City of Yow	ii, State)		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attencompletely filled in by the fune	ledical (29a. Certifier 1 Certifying P	nysician: To the bes miner: On the basis and manner s	of examinat	wledge, deat ion and/or in	h occurred vestigation	at the tim	e, date an pinion, dea	d place, a th occurre	nd due to the o d at the time, o	ause(s) an late and pl	nd manner as s ace, and due t	stated. o the cause(s)
	o the	Me	29b. Signature and title of certifier					c. License					signed (Month,	
	P S P O		Wellan G. 6 M	ne h				735	206			mou	1 12.	2005
			30. Name and address of person who	completed cause of	death (Item	23a) (Type.	Print)		,		WASHIN	_		•
	NB		William TITA	nus an	11701	Liu	nord	n Ro	md,	Fat	WASHIN	stan	may	Ind.
		ate	31. Date filed (Month, Day, Year)	32. Reg	trar's Signat	ture						,	•	

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artmei ertifica			ind Mental	Hygieri Reg. N	0 0	5	18116
	Physici	an	1. Decedent's Name (First, Middle, La	ist)					2. Date Mont	of Death h D	ay	Year	3. Time of Death
	/Medic		Ruth Ann	Chapman					May 1				7:00 A M
	Examin	er	4a. Facility Name (If not institution, gi					Location of	f Death		c. County		
			10505 Cedarville 5. Social Security Number 6.		ge (In yrs. last birthda)	-	ndyw er 1 Year	1 ne tf Under 2	24 Hrs. 8. Date	of Birth			orge s
	Funeral Director		577-32-9002	1 ☐ M 2 🔀 F	78 Yrs.	Months		Hours	Min. Aug.	th. Dev. Yee	926		otace (State or Foreign otry) ington DC
	ס		Usual Residence of Decedent		, , , , , , , , , , , , , , , , , , , ,			1	η tag s	1, 1	JE0	Masii	riigcon be
	rylan ihow		10a. State 10b. County		10c. City, Town or I	ocation.						1	Od. Inside City Limits
	e Ma	cto	Maryland Prince	George's	Brandywi								1 ☐ Yes 2 🕅 No
	vith th	Dire	10e. Street and Number	-			p Code				Citizen of W		
	s 23	eral	10505 Cedarville	Rd., #926	Fire in U.S. 12		20613		ia? (Casaily Van		ted S		ean Indian,
	Item Item	Funeral Directo	11. Marital Status 1 □ Never Married 2 □ Married	Armed Forces?	No.	If Yes, spe	ecify Cuba	n, Mexican.	gin? (Specify Yes , Puerto Rican, et	c.)		k, White,	
920	urs al	by	3 X Widowed 4 □ Divarced	If Yes, Give Year or Dates:		1 🗌 Yes	21 No	Specify:			Specify	Whi	te
21215-0036	72 ho	Completed	15. Decedent's E (Specify only highest gr		16a. Dec	edent's Usu	ual Occupa	ation during most	of working	16b.	Kind of Bu		
2	thin le.	nple	Eternentary/Secondary (0-12)	College (1-4or	5+) life.	DO NOT	use retired)	o. nog				
7	tygier her th			41	רט	spatc	ner	10 Matha	r's Name (First, N				Company
and	ntal Hed of	Be	17. Father's Name (First, Middle, Las										
Maryland	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I marked other than "natural", or items 23s or 28s-f ahow umatic svent, the Medical Examinational be notified at	ဥ	John Joseph Cotti		19h Mai	ling Addres	s (Street a		/ieve Fra ror Rural Route /				(Code)
Ma	ith an		Jody P. Chapman-S		- Lac				linton, N	-		Otato, Esp	333,
ē,	s 1 and Health Item 27 other te		20a. Method of Disposition		20b. Place of Disp	osition (Na	ame of		Date		Location -	City or To	own, State
E O	Pages nent of int: If it		1 🗖 Burial 2 ☐ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Special Control of		Arlington			.	06-15-2	nns Ar	lina	ton	Vivoinia
Baltimore,	그 된 원 중 .	Ì	21. Signal are of Funeral Service Lice	nse <i>e</i>		2. Name a	ind Addres	s of Facility	/				
m	Depa Impo eny ir		Hack 13 13	12 Karrin	0053	duntt P. O.	Fune Box	eral H 156.	lome Waldorf.	MD 2	0604-	0156	
	5		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused one cause on each li	ine death. Do not ei	nter the mo	de of dying	g, such as o	cardiac or respira	ory arrest,			Interval Between
	Physician		Immediate Cause (Final disease or condition	. Eso	phaseal	Can	CPV	_					S morths
45	/Medical Examiner		resulting in death)		consec ence of):								
ı	Lydiiiiici	<u>_</u>	Sequentially list conditions, if any, leading to immediate	b. Due to for as	a consequence of):								
	ted nsit	Examiner	cause. Enter Universiting Cause (Disease or injury	Coc	21 O O O O	rto.	/ 1	i Ca	0.0				
	al-tra	xar	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):	100	, ,	" TEU	1.				
8760,	death certificate be executed e attending physician and od for use as the burial-transit		· ·	d									
9	tificat 19 phy as th	Physician/Medical										ĺ	
Вох	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		□Ectopic p	oregnancy			11	23d. Date		
	e dea	sici	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4☐Pregnant a 9☐ Unknown		Other (s					Mon	ונוו	Day Year
P.0	that the de led by the a detached f		Part II. Other significant conditions	contribution to death t	out not reculting in the	underhina	Called Give	on in Part I	230	Did tobacco	use contr	ibute to th	ne cause of death?
ds,	90	1 by	Tarrii. Salar significant socialists	commoding to addit t	of not resulting in the	andonying	cause give	911 HI 1 QUE.	200.	1 ☐ Yes			abty 4 □Unknown
Vital Records,	w requir	Completed							242	Was an	245 V	Vara auto	psy findings available
Re	The lav	ш								autopsy performed?	, q	rior to cor leath?	inpletion of cause of
<u>e</u>	ician: Th certificate rector, pag	e Co	25. Was case referred to medical					26 Diage	of Death (Check		10 1	Yes	2□ No
	ysician: The is certificate hadirector, page	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 ER/Outpatie	ent 3 D	OA Othe		rsing Home 5	-	6 ∏Oth€	er (Specifi	v) -
0			27. Manner of Death	28a. Date of Inju	ry 28b. Time		28c. Injury Work			cribe how inj			,
joi	Attending Physician: r death. ector: After this certificaby the funeral director.	atio	1 Natural 5 Pending 2 Accident Investigation	n	, roa, mary	М		Yes 2□N	No				
Division of	l or Attendation after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not to determined	289. Place of In	ury - At home, farm, s c. (Specify)	treet, factor	ry, office			tion (Street a or Town, Sta		er or Ruma	l Route Number,
Ω	urs af urs af yral D								N				
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier 1 ✓ Certifying P (Check only 2 ☐ Medicel Exa	hysician: To the best miner: On the basis o and manner st	f examination and/or i	th occurred nvestigation	d at the tim n, in my op	ne, date and pinion, deat	d place, and due t h occurred at the	o the cause(time, date ar	s) and mar nd place, a	nner as st ind due to	ated. the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and tyte of certifier	7	ateo.	29	c. License	number		29d. D	ate_signed	(Month, i	Day, Year)
	⊢≯⊢ŏ		Muela &	To	- MU	1	100	620	397	7	1/61	165	
0			30. Name and address of person who	completed cause of c	death (Item 23a) (Type	, Print)	, 00	1 000	- i /	, ,	1		
1	85		Michael R		49 50	00	tut	hh)qx	in the	ind	MU	20746
ħ.	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 7	32. P gistr	ar's Signature	heat	,		9				

			1 - For State Registrar	State of Marylar		artment of F		Mental H	/giene) () 5	18117
	Dhyoie	ion	1. Decedent's Name (First, Middle, Las	1)				2. Date of D	eath Day	Year	3. Time of Death
	Physic /Medi		Carolyn	June	СОСН	RAN		May	20, 200		2:50 P M
	Exami	ner	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Deat	h	4c. County	of Death	
			Garrett County Me				Dakland			Garret	
	Funeral		5. Social Security Number 6. Se	TM 2RTF	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		irth lay, Year)	9. Birthpla Counti	ace (State or Foreign
	Director	ļ	232-64-0427 Usual Residence of Decedent	66	113.			April	13,1939	Mar	yland
	/land		10a. State 10b. County	10c. Cir	ty, Town or Lo	cation				10	d. Inside City Limits
	Man,	to	WV Rat	ndolph		17.11	- d				1 ☑ Yes 2 ☐ No
	r 28e	Director	10e. Street and Number	rdo I pri		10f. Zip Code	cins		10g. Citizen of V	Vhat Countr	rv?
	h witi	ie D	1014 S. Henry Av	/enue			26241			USA	í.
	deat	by Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H f Yes, specify Cuba		pecify Yes or N	o- 14. Race	e - America	
9	or ite	F	1 Never Married 2 X Married	1 ☐ Yes 2 🛣 No If Yes, Give	1	1 Tes, specify Cuba 1 ☐ Yes 2 🔀 No		o Hican, etc.)		k, White, et	
8	urai',	d b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		THES ZEENO	<i>Зреспу:</i>		Specify	: Whi	te
21215-0036	within 72 hours efter death with the Maryland ene. than "netural", or items 23e or 28e-f show the Medical Examinar must be notified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occup kind of work done	during most of wa	rking	16b. Kind of Bu	siness/Indu	ustry
121	l within iene.	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)				
	Hygie Hygie Sther t		12th 17. Father's Name (First, Middle, Last)			Legal Se				Offic	e
Maryland	ntal her o	Be		11				_	, Maiden Sumam		
Ž	hould d Me mark matic	5	Joseph Cat 19a. Informant's Name/Relationship (7)		orman		Gertru		Eunice		ling
Ma	s 1 and 2 should be filed within 72 hours efter death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "netural", or items 23e or 28e-f show other traumatic event, the Medical Examinar must be notified at	8 1				g Address (Street					Code)
	1 and 2 Health		Robert L. Cochran		LUL	4 S. Henn sition (Name of	y Avenue	Elkin Date	s WV 26		un State
Baltimore,	Pages nent of ant: if it		1 🔀 Burial 2 □ Cremation 3 🗆	Removal from State	cemetery, cren	natory or other plac	1		ZUC. LUCATION -	City of Tow	m, State
뜵	permit. Page Department of mportant: tf any injury or ance.		* 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service Licenters)	Gar		o. Mem. C		3/05	0aklan	d, Ma	ryland
Ba	permit. Departmimportainson inju		21. Signature of Pulleral Service Con-	Carl War		. Name and Addre			32 S. S e		
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	instings that accord the deep		tewart Fu			Oakland,		1and 21550 Approximate
	Frysician (Medical Examiner physician and physician and the pniral stransit the pniral stransit than the pniral stransit that the pniral stransit than the pniral stransit than the pniral stransit than the pniral stransit than the pniral stransit than the pniral stransit than the pniral stransit than the pniral stransit than the pniral stransit than the pniral stransit than the pniral stransit than the pniral stransit than the pniral stransit than the pniral stransit than the pniral stransit than the pniral stransit than the pniral stransit than the pniral stransit that the pniral stransit	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence. Due to (or as a consequence.	uence of).	al C	erdoro	susul-	- Acycle	est.	Donel and Depath Only S
8760,	siciar buris	dicai E		` '							
189	a 는 는	edic		J							
.O. Box	ut the death certific by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	I death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery oth Da	r ay Year
<u>α</u>	the ed	by Pt	Part II. Other significant conditions co	ntributing to death but not resi	ulting in the ur	derlying cause give	en in Part I.	23e. Did	obacco use contri	bute to the	cause of death?
rds	requires een signe hould be							10	Yes 2□No	3 🗌 Probab	oly 4 known
Records,	> 4	Completed						24a. Was	an 24h W	lara autono	u findings available
Re	o	mc						auto	psv pr	rior to comp eath?	y findings available pletion of cause of
_	iiclan: Th certificete rector, pag		25. Was case referred to medical				00.01	1 Yes	2 No 1	☐Yes 2[□ No
>	Physiclan: this certific ral director,	To Be	examiner?	lospital: 1 Inpatient 2	EB/Outpatient	3□ DOA Othe	26. Place of Dea		one) dence 6 □Othe	. (016.)	
		ä	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury	at		how injury occurre		
ion	Attending I r death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work M 1□`	(? /es 2 □ No				
	I or Attendi after death. Director: A I in by the fu	ifici	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho	me, farm, stre	et, factory, office		28f. Location (Street and Number	r or Rural F	Route Number,
Ö	al or A s after il Dire	Certification;	4 - Homicide	building, etc. (Specify	v)			City or To	wn, State)		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical (29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowner on the basis of examinat and manner stated.	wledge, death tion and/or inv	occurred at the timestigation, in my op	e, date and place pinion, death occur	and due to the red at the time,	cause(s) and man date and place, ar	ner as state nd due to th	ed. ne cause(s)
	To t withi To tl	Ž	29b. Signature and title of pertifier			29c. License	number		29d. Date signed	(Month, Da	y, Year)
)			1/4			D23	979		May 23	3. 200)5
			30. Name and address of person who co	empleted cause of death (Item	23a) (Type, F				-144 Z	, 200	, ,
			Robert A. Gorals			rth St.,	Oakland	MA 21	550		
	, Sta	.4	31. Date filed (Month, Day, Year)	22 D. Matenda Cinnet	Acces		DALBINI		330		
	Registr	ar	MAY 2 3 2	005	10. 14	78-6					

State of Maryland / Department of Health and Mental Hygiene U 🕽 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 13, 2005 **Physician** Year S. Robert 10:15 A Collins /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 12204 Sir Lancelot Drive Glenn Dale Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** Birthplece (State or Foreign
Country) 8. Date of Birth (Month, Day, Year) 1 ☑ M 2 ☐ F 578-05-8703 Yrs. Director Nov.6, 1915 Washington, DC Usual Residence of Decedent death with the Maryland 10b County 10c. City, Town or Location 10a State show 10d. Inside City Limits itam 27 is marked other than "natural", or itams 23a or 28a-f shov other traumatic event, the M. cical Examinar must be richined at Maryland Prince George Glenn Dale Completed by Funeral Director 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 12204 Sir Lancelot Drive 20769 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ** Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 Widowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Plumber Construction 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Thomas Collins Marie Estelle Douglass 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 siment of Health an Patricia Jean Ates/Daughter 12204 Sir Lancelot Drive Glenn Dale, MD. 20769 20a. Method of Disposition

12 Dremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 Department in important: If any injury or once. Resurrection Cemetery 5/16/05 Clinton, MD. ^¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signal of Funeral Service Ligensee 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) rostate **Physician** ance car /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, plassass or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 ☐ Yes XXXNo Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₩ No P 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XX Natural 5 Pending 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D26287 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year) MAY 1 6 2005

7305

107 Registrar's Signature

College Park Mis 20743

			1 - For State Registrar	State of Mary		artment of rtificate of		nd Mental H	ygiene () (05 8 9
	Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, La Marie H 4a. Facility Name (If not institution, give BPSI NUSSIA	Culves estreet and number)	abilitation	4b. City, Town,	1	2. Date of I Month May 1 Death	Day	2
	Funeral Director		Social Security Number 6. S		yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2	Min. (Month, I	7.0	Birthplace (State or Foreign Country) MD
	e Maryland 8a-f show Hilled at	ctor	10a. State 10b. County Worcest		c. City, Town or Lo Berlin	eation				10d. Inside City Limits 1 XYes 2 □ No
	s with th	I Dire	10e. Street and Number II9 N. Main St.			10f. Zip Code			10g. Citizen of V	What Country?
9600	be filed within 72 hours after death with the Maryland nat hygiene. od other than "natural", or Items 23a or 28a-f show event, the Madical Examinar must be notified at	d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 ☑ No	ban, Mexican, Specify:	in? (Specify Yes or N Puerto Rican, etc.)	lo- 14. Rac Blac	e - American Indian, ck, White, etc. :: White
1215-	within 72 hiene. rthan "nati the Madica	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occu kind of work done DO NOT use retire armer	ipation e during most ed)	of working	Agrici	usiness/Industry
Maryland 21215-0036	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Mi	To Be C	17. Father's Name (First, Middle, Last) Zadok Holston			<u> </u>		s Name (First, Midd. e Townsei	le, Maiden Sumam	
Mar			19a. Informant's Name/Relationship (Renee Elizabeth					or Rural Route Num , Bowie,		
Baltimore,	Page ent o nt: If ry or		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specifi	Removal from State	Ob. Place of Dispo		ace)	Date 5-18-05		City or Town, State
Balti	permit. Pa Departmen Important; any injury once.		21. Signature of Funda Service Lie		22	. Name and Addre	ess of Facility		bage Fun	neral Home
8760,	cate be executed by American and Cambridge b	dical Examiner	23a. Part1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cor Due to (or as a cor Due to (or as a cor Due to (or as a cor	nsequence of):			ardiac or respiratory		Approximate Interval Battween Onset and Death
O. Box 6	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	÷y		23d. Date Mor	e of delivery hth Day Year
rds, P	w requires tha been signed I should be det	by	Part II. Other significant conditions of							ibute to the cause of death? 3 Probably 4 Dhknown
Vital Records,		Completed	Chronic Obs	structive	pulmi	onary	disc	24a. Wa auto peri 1 🗆 Yes	opsy p formed? d	Vere autopsy findings available rior to completion of cause of eath? Yes 2 No
of	Physician: or this certifical aral director, p	n; To Be	25. Was case referred to medical examiner? 1 Yes 2 140 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatien	t 3 DOA Ott	her: 4 Nurs	Death (Check only ing Home 5 Res 28d. Describe		
Division	If or Attending Fafter death. Director: After	Certification;	1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined		At home, farm, stre	M 1	Yes 2 □ No	28f. Location	(Street and Numbe own, State)	er or Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dii completely filled in	ledical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my iner: On the basis of exar and manner stated.	knowledge, death mination and/or inv	occurred at the ti restigation, in my o	ime, date and opinion, death	place, and due to the occurred at the time	cause(s) and mar , date and place, a	nner as stated. Ind due to the cause(s)
}	To the I within 2. To the I complet	W	29b. Signature and title of certifier	Suffin,	MO	29c. Licens	se number 30067	95 (DE)	29d. Date signed 5-15-0	(Month, Day, Year)
8	T 3	te	30. Name and address of person who of KRISTINE GR 31. Date filed (Month, Day, Year)	complete cat/ of death M 32. Significantly Significantly Significantly Significantly Significantly Significantly Significantly Significantly Significantly Significantly Significantly Significantly Significantly Significant Significa	(Item 23a) (Type, I 1269 ignature	Print) COASTY	te the	othway t	ENUC	(Month, Day, Year) S K ISLAND DE
	Registr	T.	MAY 1 7 2	UUD	J. A.	The same				

			For State Registrar	State of Marylan		artment of H tificate of L			ene	05	18120
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last) LOUISE JOHA	COLL	INS			2. Date of Death	O.J.	Ž0°05	3. Time of Death 11:53P M
	Examir		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of Dea	ith	4c. Count	y of Death	
			8400 RAVENSWOOD ROA			NEW CARR			PRINC	CE GEC	
ı	Funeral Director		213.74.8307	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		^{Year)} 1905	Coun	ace (State or Foreign try) ington, DC
	Maryland 9-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Geo		y, Town or Lo	cation rollton				10	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	or 28	Directo	10e. Streel and Number			10f. Zip Code		10	g. Citizen of	What Coun	try?
	1h wi	ai	8400 Ravenswood R	oad		20784			U.S.A	. •	
036	be filed within 72 hours after death with the Maryland Ital Hyglene. Id other then "natural", or Items 23a or 28e-f show event, I'm Modical Exafricat must be coefficial at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 🛣 No		Specify Yes or No- irto Rican, etc.)	Bla	ce-Americ ck, While, o by Whit	etc.
Baltimore, Maryland 21215-0036	hin 72 ho e. en "natur Medical	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occupa kind of work done o DO NOT use retired	turing most of w	orking 1	6b. Kind of B	Business/Ind	lustry
2	filed wil Hygien other the	Con	6th		Но	usewife			Domes		
/land	2 should be file of and Mental Hy is marked oth reumatic event	ø	17. Father's Name (First, Middle, Last) Frank J. Stump				18. Mother's Na	ame <i>(First, Middl</i> e, <i>M.</i> ie Anders		me)	
a	2 should and Men is marke eumatic		19a. Informant's Name/Relationship (Typ	pe, Print)	19b. Mailir	ng Address (Street a	and Number or F	Rural Route Number,	City or Town	, State, Zip	Code)
ore, N	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other treumatic a once.		William T. Collin 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	20b. P		itchess Co sition (Name of natory or other place		lney, Mary	land 2		wn, State
Ĕ	Pag ment ant: I		'4 Donation 5 Dother (Specify)	Co				14/2005 A		ton, \	/irginia
Ball	permit Depart Import any in		21. Signature of Funeral Service License		H 1	Name and Addres INES-RINA 1800 New	s of Facility LDI FUN Hampshi	ERAL HOME, re Ave, Si	INC.	Spring	g, MD 20904
	Fnysician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death e cause on each line. Congestive Due to (or as a consequence)	Heart		g, such as cardia	ac or respiratory arres	st,		Approximate Interval Between Onset and Death
	Examiner	Jer	Sequentially list conditions, if any leading to immediate	Due to (or as a consequence)		isease				1	lO Years
8760,	certificate be executed iding physicien and ise as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Hypertension Due to (or as a consequent							
.O. Box 6	death e atter	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of di 9 ☐ Unknown	Ideath 3	Ectopic pregnancy Other (specify)				ate of deliver	ry Day Year
rds, P	The law requires that the te has been signed by the hage 2 should be detache	by	Part II. Other significant conditions con	ntributing to death but not resi	ulting in the u	nderlying cause give	en in Part I.		acco use con 2 ⊠ No		e cause of death? ably 4 Unknown
II Record	(0) 11	Completed						24a. Was an autopsy performe	ed?	Were autop prior to con death? 1 \(\text{Yes} \)	nsy findings available inpletion of cause of
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:		Othe		eath (Check only one			
ō	ding Phys h. After this of tuneral dir	ion: To	27. Manner of Death 1 XNalural 5 Pending	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	at Nursing	Home 5 🖾 Residen 28d. Describe how)
Division	or Atten	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, elc. (Specify	ome, farm, str y)			28f. Location (Stre City or Town,		ber or Rural	Route Number,
	To the Hospitel within 24 hours a To the Funerel Completely filled	edicai		sician: To the best of my kno ner: On the basis of examina and manner stated.							
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	(1)		29c. License			d. Date signe	-	Day, Year)
	2/		, Pasc	nunc		DO6	>14	779	2/11	10	7
_			30. Name and address of person who co	-HEWM	23a) (Type,	Print)	KEL	AC 0000	THE	ALE	E 2 0 737
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 6 2005	32. Registrar's Signa	dure / DOA						

		For State Registrar	State of M	larylan		artment of H tificate of L		ind Me		iene 0 0 5	18121
		Decedent's Name (First, Middle	, Last)					2	2. Date of Deatl Month		3. Time of Death
Physici /Medic		EDNA	LOUISE	DU	NKLEY			ı		, 2005	7:25p M
Examin		4a. Facility Name (If not institution	give street and number)		4b. City, Town, or	Location of	f Death		4c. County of E	Death
		SOUTHERN MARY				Clinton If Under 1 Year	n, Md.		Date of Dieth	P.G.	Distribution (Contraction
Funeral Director		5. Social Security Number 095-24-8286	6. Sex 1 □ M 2 ☐ F 7. A	ge (<i>in yr</i> s. : 85	last birthday) Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day,	Year) 4,1920	Birthplace (State or Foreign Country) Halifax, Va
		Usual Residence of Decedent						L	arch	4,1920	
irylan show	_	10a. State 10b. County			y, Town or Lo						10d. Inside City Limits
Ba-fs	Director	Md. P.G.		Cl	inton						1 X Yes 2 No
with the	Dir	10e. Street and Number	. המ			10f. Zip Code 20735				Og. Citizen of Wha	t Country?
C 27215-UU36 filed within 72 hours after death with the Maryland Hygiene. uther then "natural", or Itams 23a or 28a-f show ant, fre Madical Exactinat rust be notified at	Funeral	7520 Surratts	12. Was Decedent	Ever in U.	.S. 13. V	Vas Decedent of Hi	spanic Orig	in? (Speci	ify Yes or No-	U.S.A.	American Indian,
or Itar		1 Never Married 🏖 Marri				Yes, specify Cuba		, Puerto Ri	can, etc.)		Vhite, etc.
Z1Z15-0036 d within 72 hours af giene. rr than "natural", or IT a Modical Exert	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			∏Yes 22€No	Specify:			Specify: B1	ack
natu	Completed	15. Decedent (Specify only highes			16a. Deced	lent's Usual Occupa kind of work done of DO NOT use retired	ation during most	of working	7	16b. Kind of Busine	ess/industry
withir ene.	ошо	Elementary/Secondary (0-12)	College (1-4or	5+)		ewife	,			Self	
ING 21215-UU36 be filed within 72 hours after death with the Marylan tal Hygiene. Ind other then "natural", or flams 23a or 28a-f show avant, fre Medical Exercities must be neitling at	0	10th 17. Father's Name (First, Middle, 1	Last)				18. Mother	r's Name (First, Middle, M	faiden Sumame)	
	To B	Van Farrar					Lucy	y Fai	rrar		
re, Maryland s 1 and 2 should be file f Health and Mental Hy itam 27 is marked oth other traumatic avant		19a. Informant's Name/Relations				g Address (Street a				•	
C = '4 F		John Burrell-	-Son	- I	_						Va.22201
Saltimore, permit. Pages 1 ar Department of Hea mportant: If item any injury or otha		20a. Method of Disposition 1				sition (Name of natory or other place		Dat		20c. Location - City	
ti Partimentant:		'4 □Donation 5 □Other (Si		Вe		Chu.Cem.			2005 C	lover.V	a.
Baltimor permit. Pages Department of I Important: If it any injury or o		21. Signature of Fune al Service I	Licensee	-	1-20	. Name and Addres			Pada 1	NT TO	
		23a. Part1. Enter the disease, or	complications that cause	d the deat							Approximate
Physician .		shock, or heart failure. List Immediate Cause (Final			· Orack	c Cano	15000	0	nii	0	Interval Between Onset and Death
/Medical		disease or condition resulting in death)	aDue to (or a:			Cano	L-0 64	n ala	n 1/13	task	Sylan
Examiner		Sequentially list conditions,	b								
pe tis	Iner	cause. Enter Underlying	Due to (or as	s a conse	uence of						
ecute and -trans	Examln	Cause (Disease or injury that initiated events resulting in death) Last	c	a consequ	uence of):						
58 / 50, ficate be executed physician and s the burial-transit	alE			- u oonooq	30.100 017.						
68/ ifficate	edicat		d								
at the death certification the attending parties attending partened for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pregnancy				23d. Date of	,
deat deat	slcia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant a			Other (specify)				Month	Day Year
Hecords, P.O. The law requires that the tte has been signed by the page 2 should be detache.	Phy	9 Unknown			hi a d		1.0.1		00- 014-1		1- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1
IS, F	by	Part II. Other significant condition	ns contributing to death	out not res	uiting in the ur	ideriying cause give	an in Parti.				te to the cause of death? Probably 4 XUnknown
Kecords, he law requires t e has been signe ige 2 should be o	Completed								-		
Hec ne law ne law ne law ne law ne law	Idm								24a. Was ar autopsy perform	/ prior	autopsy findings available to completion of cause of h?
	e Co	25. Was case referred to medical					OC Diese	of Dooth /	1 ☐ Yes 2 Check only one		Yes 2 No
	0 8	examiner?	Hospital:	ent 2:2	ER/Outpatient	t 3 DOA Othe	AF.			nce 6 Other (5	Specify)
	n: T	27. Manner of Death	28a. Date of Inj	urv	28b. Time of Injury	28c. Injury Work				w injury occurred	
VISION Attendin death. ctor: Al	atlo	1 Natural 5 Pendin 2 Accident investig	ation	.,	,		Yes 2□N	No			
DIVISION or Attending after death. I Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ned 28e. Place of Ir building, e	ijury - At ho itc. (Specif	ome, farm, stre y)	et, factory, office		28	f. Location (Str City or Town,		r Rural Route Number,
spital o		20a Carifia	Phonisis T. d. h.		1-2 2			1-1			
To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier T Certifyin (Check only one)	g Physicien: To the besi Exeminer: On the basis and manner s	of examina	tion and/or inv	estigation, in my of	ne, date and pinion, deat	h occurred	at the time, da	use(s) and manne ite and place, and	r as stated. due to the cause(s)
To tha Hos within 24 h To tha Fur completely	Me	29b. Signature and title of certifier				29c. License	number		29	d. Date signed (M	
		1 850				04.	5365	5			12-05
(2)		30. Name and address of person	who completed cause of	death (Item	23a) (Type, I	Print)	2.7	(.,	/	Trichael	Sidazous M.
		31. Date filed (Month, Day, Year)	32 Regist	rar's Signa	U AS W	7/2 ~()	601	45			,
Sta Registr		31. Date filed (Month, Day, Year) MAY 1 7 2	005	, J.	he	E .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item 5 per Th 8844 6-22-05 vt
State of Maryland 7 Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month James Fletcher Doia 2005 May 14 3:30 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rising Sun

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Calvert Manor Healthcare Center Cecil 070 00 0 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**X**) M 2□ F Months 070-22-0900 85 June 18,1919 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Cecil Rising Sun 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1881 Telegraph Road 21911 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☑ Widowed 4 □ Divorced White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Law Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Shaw Doig Laura Christina Wight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 351 Wedgewood Road, Newark, DE Janet Walker/daughter 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition May 17-2005 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) R.T. Foard & Jones, Inc. Newark, Delaware 22. Name and Address of Facility R.T. Found & Jones, Inc. 122 West Main St., Newark, DE Enter the disease, or complications that caused or heart failure. List only one cause on each lin he death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final pres mone disease or condition resulting in death) 2 WEELS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Liseass or injurthat initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Parkinson's Discosp 22500 1 🗌 Yes 3 Probably 4 Unknown congestive heartfallure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 20 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death Check only one) examiner' Other: 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of De ah 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation М 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

Prysician /Medical **Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit the attending physician and Division of Vital Records, P.O. Box 68760. After death. within 24 hours after death **To tha Funaral Director:**

Physician

/Medical

Examiner

Be Completed by Funeral Director

10a. State

MD

21. Sign

23a, Part1

Examiner

Physiclan/Medical

þ

Be Completed

10

Certification:

Medical

State Registrar

29a. Certifier

(Check only one)

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "natural", or itams 23a or 28e-f show any injury or other traumatic event, the Medical Exeminary.

3+IVA

Prashant 31. Date filed (Month, Day, Year) 7 2005

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shukle

15 S. Parke St. #400 Agerdeen 32. Registrar's Signature

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D00048050

MD 21001

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month ROBERT ARTHUR DIXON, SR. MAY 2005 16 9:52a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chester River Hospital Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F 218-16-6718 83 Director Nov 1 1921 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f show traumatic evant, the Medical Examinat must be notified at 10d. Inside City Limits Director MD Kent 1 ☐ Yes 2X No Worton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26588 Lambs Meadow Rd. 21678 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No δ Specify Specify: White 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Battery 6 Assembly Line Worker Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Pages 1 and 2 should be nent of Health and Mental ant: If itam 27 is marked o William Dixon Grace Camp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Dixon, Sr. 21179 Texas Ave. Chestertown, MD. 21620 (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If its any injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Galena Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) Galena, MD. 5/20/05 21. Signature of File at Service Line Galena Funeral Home of Stephen L. Sc 118 West Cross St. Galena, MD. 21635 MO0510 23a Perrit. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in Seath) **Physician** wom ea /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I ary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a donsequence of) attending physician and for use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. been signed by the should be detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ of Vital Records, 2 12 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 2 1 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manney of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred injury at Work? Certification; Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō 1 Crititying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ulun mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kin Kue Wun, 415 Washington Ave. Chestertown, MD. 21620 $M \cdot D$. 31. Date filed (Month, Day, Year) 32. Register's Signature State 1 7 2005 Registrar

		For State Registrar	State o	of Maryland		artment tificate			ınd M		gierre Reg. No.	005)	181	24
Physici	an	Decedent's Name (First, Middle) A								2. Date of Dea May 11) 5	ear	3. Time o	of Death 9 p M
/Medic	al	Ann Loretta 4a. Facility Name (If not institution,		mber)		4b. City.	Town, or	Location of		Tay 11		County of	Death	12.5.	у Р
Examin	ier	Chester Rive		,		,		rtown				nt			
Funeral Director		5. Social Security Number 202-26-1481	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. la	st birthday) 2 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs Min.	8. Date of Birt (Month, Da April	h (7 , 1 9	933	Birthp	place (State ntry)	or Foreign
and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							1	Od. Inside (City Limits
Maryli f sho	ō	MD Cecil		Warw	rick									1 🗌 Yes	s 2 ∑ No
n the l	Irec	10e. Street and Number				10f. Zip					10g. Citiz	en of Wh	at Cour	ntry?	
th wit 23a c	aiD	148 Main Sti	reet				912				US				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, Ite Medical Examine must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	Armed Fo	2 🕅 No	1	Was Deced f Yes, spec 1 ☐ Yes 2	**	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No Rican, etc.)		4. Race - Black, Specify:	White,		
72 hou		15. Decedent (Specify only highes	s Education		16a. Dece	dent's Usua	al Occupa	ition	of working	20	16b. Kin	d of Busin	ness/Inc	dustry	
ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of wor DO NOT us emake) " " " " " " " " " " " " " " " " " " "	or works	,9	Ωτ	m Ho	m o		
iled w dygier ther th		17. Father's Name (First, Middle, I	ast)		пош	ешаке	L	18. Mothe	r's Name	(First, Middle,					
d be f ental h	o Be	Edwin McLaus								Merk1					
nd 2 shoul ith and Me 27 is mark	2	19a. Informant's Name/Relationsh Karen Quinn/da								I Route Numbe		Town, St	ate, Zip	Code)	
s 1 ar of Hea item	14 8	20a. Method of Disposition		ce ce	ace of Dispo ametery, crei	natory or o	ther place	9)		ate				own, State	
Page nent c		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (St		Ches	•			1		2, 200					
permit. Departitingorth any inj		21. Signature of Funeral Service I	Helpil	20	22	Fello 130 S	d Addres WS, peer	s of Facilit Helfe Koad	nbei , Ch	n & Nev	mam	Fune MD 2	162	Home O	, P.A.
Physician /Medical Examiner physician and physician and physician and the pniral-transit	al Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	each line.	ence of):	tre (and	g, such as	culo	un Di	Second	-€		Approxima Interval Be Onset and	tween Death
To the Hr spital or Attending Physicien: The law requires that the death certificate be executed within 24 ours after death. To the Funeral Director: After this certificate has been signed by the attending physician and complete; filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live	utcome of pregnal birth 2 Fetal pant at time of de	death 3[⊒Ectopic pr ⊒Other (sp					2	3d. Date (əry Day	Year
uires tha	by	Part II. Other significant condition Seven Pen's	heral Va	death but not results	ilting in the u	nderlying c		en in Part I. La		23e. Did t	4			he cause of pably 4	
II necolus, The law requires are has been signing page 2 should be	Completed	Dictoles m	e of s	ight	foot					24a. Was autor perfo 1 🗆 Yes		pridea	or to co ath?	psy finding mpletion of 2 No	s available cause of
VICAL ician: T sertificat ector, pi	Be	25. Was case referred to medical examiner?	Hospital:				Othe	11		(Check only o					-
Phys r this ral dir	- T	1 ☐ Yes 2/1 No 27. Magner of Death	28a. Date	of Injury	ER/Outpatier 28b. Time o		28c. Injury Work	4/2500	-	me 5 Resident				(y)	
OTI ding th. : Afte fune	tlon	1 Natural 5 ☐ Pendin 2 ☐ Accident investig	y ·	nth, Day Year)	Injury	М		k? Yes 2 🔲 I	No						
UNISION al or Attending s after decth. I Director: After id in by the fune	Sertification:	3 Suicide 6 Could a determined	ined 289. Plac	e of Injury - At ho ding, etc. (Specify	me, farm, st	reet, factory	y, office			28f. Location (, City or Tox	Street and vn, State)	d Number	or Rura	al Route Nu	mber,
To the Hospital or Attending Physician: within 24 Tours after death. To the Funeral Director: After this certifical complete, filled in by the funeral director, to	edical C		g Physician: To th Examiner: On the t and mar												(s)
To the within To the Comp	Ž	29b. Signature and title of certifie	Vh	too, ins)	290	C. License	763	36		15	1121	65	Day, Year)	
		30. Name and address of person	who completed cau			Print)	ten	Bre	Ct	la facts	m /	Md 2	10	20	
St Regist	ate rar	31. Date filed (Month, Day, Year) MAY 1	3 2005	Redistrar's Signar	ture	1-1	9								

		1 - For State Registrar	State of	Marylar		artmen <i>rtificat</i>			and M	ental I		rije () ()	5	1812	5
Dhuoisi		1. Decedent's Name (First, Middle, Last,)	•		-				2. Date of		Day	Year	3. Time of Dea	ath
Physici /Media		Joan McDo	nald		DiPl	acido				May	9,	2005		10:45ª	М
Examir	ıer	4a. Facility Name (If not institution, give	street and numb	er)		4b. City,	Town, or	Location of	of Death			4c. County	of Death		
		Montgomery Hospi					kvil		04 1140			Mont	gome		
Funeral		5. Social Security Number 6. Sec	M 280F		last birthday) Yrs.	Months Months	Days	If Under	Min.	8. Date of (Month,	Day, Y		Cou	place (State or Fo intry)	reigi
Director		Usual Residence of Decedent		6	2					July	31,	1942	Ire	eland	
yland yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation								10d. Inside City Li	mits
Mar Mar	ţ	Maryland Montgom	ery		0	lney								1 □ Yes 2 ₹] No
h the	Director	10e. Street and Number				10f. Zip	Code				10g	. Citizen of \	Vhat Cou	intry?	
th will	aD	17570 Macduff Av	enue				2083	2				US	SA		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. I mit mortant: if Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and the motified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	∍s? ☑ No	i	Was Deced f Yes, spec 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto l	cify Yes or Rican, etc.)	No-		k, White		
d within 72 hours aft giene. ar than "natural", or . Ibs Mcdical Exam	Completed	15. Decedent's Edu			16a. Deced	dent's Usua	al Occupa	tion			16	b. Kind of B	usiness/Ir	ndustry	
hin 7	ple	(Specify only highest grad	College (1-4	or 5+)	(Give	kind of wo DO NOT u	rk done d se retired)	uring most	t of workii	ng					
og w	PO.	11			Fac	ctory	Wor	ker				Ander	son	Asbestos	į
d 2 should be file th and Mental Hy 7 Is marked oth traumatic event	Be (17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Mia	dle, Ma	iden Suman	10)		
Ment	2	Walter McKinstry						Ed	lna R	owney	•				
2 sho and ls ma		19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	r or Rura	l Route Nu	mber, C	ity or Town,	State, Zi	p Code)	
and ealth m 27		Louie J. DiPlacide	o/ Husba					Aven				arylan			
rmit, Pages 1 ar spartment of Hea portant: If Item y injury or other ICE.		20a. Method of Disposition 1 图 Burial 2 □ Cremation 3 图 '4 □ Donation 5 □ Other (Specify)		ate C	Place of Dispo emetery, cren toria	cemet	ther place cery	, I	May 200	-	C:	c.Location arrick reland	ferg	us,	
permit Depar Impor any in		21. Signature of Funeral Service License	Cole		50 50	name an ranci O Uni	d Address S J. Lvers	s of Facility Coll ity I	ins Blvd,	Funer	al Silv	Home I er Sp	nc ring	, Mđ 2090	01
Physician and // Medical Examiner transit the printer-transit	dical Examiner	shock, or heart failure. List of ly Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or		uence of):									Initerval Between Onset and Deatl ess than 8 Months	h
death certifi e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ SNo 9 □ Unknown	3c. If yes, outcor 1□Live birth 4□Pregnan 9□Unknowr	n 2 ☐ Feta tat time of d	Ideath 3□	Ectopic pr Other (sp					_	23d. Dat Mor	e of deliv	ery Day Year	
as tha	þ	Part II. Dther significant conditions cor	tributing to deat	h but not res	ulting in the ur	nderlying c	ause give	n in Part I.						he cause of death	
The ate h page	Completed									24a. W au pe 1 🔀 Ye	itopsy erforme	d? 6	Vere auto prior to co leath?	opsy findings availampletion of cause	able of
Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?								Check on					
Physi this c	2	1 Tes 2 No	ospital: 1 🗆 Inpa		ER/Outpatien	t 3□ DO	A Other	r: 4□ Nur	rsing Hom	ne 5□R	esidenc	e 6 Othe	er (Specil	(y)	
Attanding P death. ictor: After I y the funera	atlon:	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of I	njury Day Year)	28b. Time of Injury	M 2	8c. Injury Work' 1 🗆 Y	at ? es 2□N		8d. Descrit	e how	injury occurr	ed		
or vitter	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building,	Injury - At ho etc. (Specify	ome, farm, stre	eet, factory	, office		2	8f. Location City or	n (Stree Town, S	t and Numbi itate)	er or Rura	al Route Number,	
he Hospital in 24 hours a ha Funaral pletely filled	edical	29a. Certifier 1⊠ Certifying Phys (Check only one) 2 Medical Examin	sician: To the be ner: On the basis and manner	s of examina	wledge, death tion and/or inv	occurred a restigation,	at the time in my opi	e, date and nion, deat	d place, a h occurre	nd due to t d at the tim	ne caus ie, date	e(s) and ma and place, a	nner as s	tated. the cause(s)	
To the I within 2 To tha I complet	Σ	29b. Signature and title of certifier				29c	License	number			29d.	Date signed	(Month,	Day, Year)	
12		& Paul Barne				M	1000	2550	_		1	lan 1	3 >	2005	
1 -		30. Name and address of person who co	mpleted cause of	of death (Item	23a) (Type, I		.,	- 333					1		
		Paul Andrew Banne	en, MD		ll Prir		hilip	Dri	ve,	#327,	0 1 r	ney, M	D 20	832	
Sta Registr		31. Date filed (Month, Day, Year) MAY 1 6 2005	100	strar's Signa	ture	ES S									

			1 - State Registrar C6	ertificate of Death	ental Hygie	4000	18126
	Physici /Medi		OTIVEL DOSEDII DETTIES		2. Date of Death Month May 1	Day 2005	3. Time of Death 8:10 p M
	Examir			4b. City, Town, or Location of Death	-	4c. County of Death	
			Anne Arundel Medical Center	Annapolis		Anne A	
	Funeral Director		5. Social Security Number 398-18-2700 G. Sex 1 M 2 F 7. Age (In yrs. last birthday) 7. Yrs. Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, You Aug. 25,	9. Birth Co.	nplace (State or Foreign untry) MI
	a Maryland a-f show lifted at	ctor	10a. State 10b. County 10c. City, Town or L MD Anne Arundel	ocation Annapolis	3		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ath with th	Funeral Director	10e. Street and Number 1292 Seabright Drive	10f. Zip Code 21401	10g	. Citizen of What Cou US	
9036	permit. Pagas 1 and 2 should be filed within 72 hours after death with tha Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I' to Madical Examiner must be notified at once.	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: Korean	Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto R	city Yes or No- lican, etc.)	14. Race - Amer Black, White Specify:	
21215-0036	filed within 72 h Hygiene. othar than "natu ant, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	odent's Usual Occupation a kind of work done during most of working DO NOT use retired) CENIOR Engineer	9	b. Kind of Business/II	nghouse
Maryland 2	uld be filed fental Hygi rked othar tic evant, I	To Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name Bessie			iigiioase
	and 2 should ealth and Men n 27 is marke		19a. Informant's Name/Relationship (Type, Print) Helen B. Dellies/Wife 129	ing Address (Street and Number or Rural 2 Seabright Drive,	Route Number, C. Annapoli	ity or Town, State, Zi	p Code) 401
Baltimore,	Pagas 1 Imant of Ho tant: if iter		'4 □Donation 5 □Other (Specify) Metro C	position (Name of matory or other place) rematory May 20		o. Location - City or T Baltimore,	
Bal	permit. Departr Imports any inje		Momes Me 4	arranco & Sons, P. <i>A</i> 95 Gov. Ritchie Hwy	, Severn	na Park, M	neral Home D 21146
	Enysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	ter the mode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if my leading to force clause. Enter Underlying Cause (Disease or injury				
8760,	cate be executed physician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d.				
.O. Box 6	I the death certifi by the attending I ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 4 □ Pregnant at time of death 5 □	□Ectopic pregnancy □ Other (specify)		23d. Date of delive	ery Day Year
rds, P	w requires that been signed to should be det	ρχ	Part II. Other significant conditions contributing to death but not resulting in the under the prenal facilities.	nderlying cause given in Part I.	23e. Did tobacc	co use cantribute to t	he cause of death? pably 4 □Unknown
al Record		Completed	Covonory artery diseose		24a. Was an autopsy performed	prior to co death?	ppsy findings available mpletion of cause of
ion of Vital	ding Phys .r After this funeral di	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury			e 6 ⊡Other (<i>Specit</i> njury occurred	(y)
Division	ital or Attandras after deathral Diractor:	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office 28	f. Location (Street City or Town, St	t and Number or Rura tate)	al Route Number,
	To tha Hospital of within 24 hours a To the Funaral D completely filled i	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deatt one) Certifying Physician: To the best of my knowledge, deatt one) Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred	at the time, date	and place, and due to	o the cause(s)
	Miti	Σ	Pett Receive up	29c. License number D24804	(Date signed (Month,	005
				AMC Ann	cycles	Md 2	1401
ı	Sta Registra		31. Date filed (Month, Day, Year) MAY 1 3 2005	ر الله	y		

Amend-Item #5 per FD AA County Hith Dept 05/20/05 ki For

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

J	0/05 KJ		1 - State Registrar	,,,,	Ce	rtificate of	Death		Reg. No.	5	8 21
	Physici	an	1. Decedent's Name (First, Middle, La	•				2. Date of De Month		Year_	3. Time of Death
	/Medi	cal	Frances Elizabe			41- O't- T	.1	May	Day 11,	Ž005	2:30 p M
	Examir	ıer	4a. Facility Name (If not institution, giv 702 Holly Avenu			4b. City, Town, o	r Location of Death Pasac	dena	4c. County	or Death ne Art	ındel
	Funeral		Social Security Number 6. S	ex 7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h		ace (State or Foreign try)
	Director			□ M 2 🖫 79	Yrs.	World Days	110dis Mill.	Jan. 1		Count	MD
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	ocation				10	Od. Inside City Limits
:	Mary Fied a	tor	MD Anne Ar	undel		Pasadena	a				1 ☐ Yes 2 No
	or 28a or 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of		try?
	23a (23a)	rai	702 Holly Avenu	le		2	1122		US	SA	
	er der Items Der m	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e · America ck, White, e	etc.
936	filed within 72 hours after deeth with the Maryland Hygiene. Hygiene. The Wealtest show ther than "natural," or items 23s or 28s-f show ent, the Mealtest Evant at must be notified at	b S	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1		1 ☐ Yes 2 🔼 No	Specify:		Specify	v: Wi	nite
Maryland 21215-0036	72 hol natura	Completed	15. Decedent's E (Specify only highest gra	ducation	16a. Dece	dent's Usual Occup	ation during most of work	ina	16b. Kind of B	usiness/Ind	ustry
21	Athin ne. han	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)	9		Home	
2	iled v Hygie ther t		17. Father's Name (First, Middle, Last)		Homemak	18. Mother's Name	a (First Middle	Maiden Suman		
au	d be id To Be	James Griffin	,			Mary G		walden ceman	10)		
ary	shou and M mari	-	19a. Informant's Name/Relationship (Туре, Print)	19b. Maili	ng Address (Street	and Number or Run		r, City or Town,	State, Zip	Code)
Σ	and 2 salth a n 27 is		Guy Stephen Deit	z/Son	8009	Cross C	reek Driv	e, Glen	Burnie	, MD	21061
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Brown the Marylan Tream of Secretary of the them of the them of the marked of the them. In the Medical Examination to the redifficial any injury or other treamatic event, the Medical Examination in a confidence.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Bomoval from State	cemetery, cre	osition (Name of matory or other place	e) Mav	14,	20c. Location -		
<u>=</u>	t. Pa		`4 Donation 5 Dother (Special	y)	-	ven Cemet		2005	Glen B		
Ba	Dep Impo any		21. Sign that of uneral Service vices	a som			ssons, P. itchie Hw				eral Home 21146
			23a. art1. Ent y the disease, or com	plications that caused the dea							Approximate
	Physician		s k, or leart failure. List only	one cause on each line.	50 h	0 4	ent-				Interval Between Onset and Death
	/Medical		dis ase f condition resulting in death)	a (or as a con	uence of):	, ,					noruns
B	Examiner	L	Sequentially list conditions,	· perio	Leva	e vas	cular	- di	eas	٩	YEARS
	led sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Du to (or as a co	r Hens						1 man v 0
,	execu n and ial-tra	Examiner	that initiated events resulting in death) Last		quence of);	V 1					years
68760	The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Medical		· hype	Tlip	Idem	ia				years
89 ×	artifica ing ph e as th	Med	IF FEMALE:								/
ê Rô	that the death ce ned by the attendi detached for use		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregring 1 ☐ Live birth 2 ☐ Fel	tai death 3[Ectopic pregnancy	1			te of deliver	y Day Year
o i	the de	Physician	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5t	Other (specify) _					
J.	s that ned b e deta		Part II. Other significant conditions		_		en in Part I.	23e. Did to	bacco use cont	ribute to the	e cause of death?
ıd	w requires that been signed be should be det	ed t	chronic obst	ructive pr	Ulmoi	vary a	reace	, X	es 2□No	3 🗌 Proba	ably 4 Unknown
Records,	e law re has be je 2 sho	Completed by		Syndron				24a. Was	sv l	orior to com	sy findings available
E I	ysician: The is certificate ha director, page	Con	·	•				perfor	rmed?	death? I□Yes 2	
Vital	sician: Th certificate rector, pag	Be c	25. Was case referred to medical examiner?	Hospital:		Cth	26. Place of Death	1004			
ō	g Phys er this eral di	n: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatie	IL 3 DOA	4 Nursing Ho		lence 6 Oth		<u> </u>
on !	ath. rr: Afte	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury		k? Yes 2 □ No				
Division of	or Atterde linecto	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, st	reet, factory, office		28f. Location (S City or Tow	Street and Numb m, State)	er or Rural	Route Number,
	pitel c		29a. Certifier 1 Certifying Pt				- 1				
	To the Hospitel or Attending Physician: within 24 hours atter death. To the Funerel Director: After this certifica completely filled in by the funeral director.	edical	(Check only one)	nysician: To the best of my kr niner: On the basis of examin and manner stated.	nowledge, deat nation and/or in	h occurred at the tir vestigation, in my o	ne, date and place, pinion, death occurr	and due to the d ed at the time, d	ause(s) and ma date and place, a	and due to	ited. the cause(s)
:	To the within To the	Me	29b. Signature and title of certifier	211	1	29c. Licens	e number		29d. Date signed	d (Month, D	ay, Year)
ľ			1000				- P4195	5	5-1	11-05	
	6		30. The and address of person who	completed cause of death (Ite	om 23a) (Type,	Print)	1 #20	6 1. 1	200	11 2	1021108
			3 Date filed (Month, Day, Year)	32#Aegistrar's Sign	nature VEXP	ran ing	inway	MUL	XXISVI	1101	1
	Sta Registi			005	M A	and a	•				

amend 5-22 per hosp. g843 5-30-05 KBH Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 5 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 08.49 AM 19 OSe O 05 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner ashington Adventist HOSpital lon comaome a If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days 1 ☐ M 2 💢 F ano Director 27 05 ar 10 none Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or itams 23a or 28a-f show Examiner must be notified at T☐Yes 2☐No Director MD Prince George Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20783 USA 5800 Peabody St. Funerai deeth 1 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: BLACK δ 3 Widowed 4 Divorced "natural", ar than "nature 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. infant infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Maggario Diallo 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health If item 27 5800 Peabody St Odia Keita 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ō 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State ö permit. Page Department c important: if eny injury or once. Washington Adv. Hosp 03 4 Donation 5 Other Specify 05 21. Signature of Funeral Se 22. Name and Address of Facility ice Licens Washington Adventist Hops. Tk.Pk., MD. 20912 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PTIANTAMESAS EXTREME /Medical Due to (or as a consequence of): Examiner PRETERM LAMA PREMINTURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed physicien and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical NIA IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) o the 9 Unknown ò ے signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 Tes Be Completed page 2 should peed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificete has 2 X No 1 Yes funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: 1 [[7]npatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No this 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 13646 HYUTTIVILE, MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GLIVER TELRACE 205 323 Wisself EDWARD 20782 31. Date filed (Month, Day, Yearl Y 3 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiefie 🛭 🗍 5 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 294mond 2-16 AM 0, 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Adventist Shing Pa omen acoma TOSP VIC 00 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) ocial Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F NIA Director 20 17-05 MARYLAND Usual Residence of Decedent with the Maryland r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits mington Was Jas 1 Yes 2 No Director DC 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be tiled within 72 hours after death with Iment of Health and Mental Hygiene.
ent: If item 27 is marked other than "natural", or itema 23a or 3 ury or other traumatic event, the Madical Examinat must be no NW ono 00 ow Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 ⊠ No If Yes, Give Year or Dates: 1' Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 BNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ٩ ree onique 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shevee Washington DC 20011 tle 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of H
Importent: If its
eny injury or of 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Jashington Adventist * 4 ☐ Donation 5 ☐ Other (Specify) 0 22. Name and Address of Facility 21. Signature of Funeral Service License Washington Adv 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** whater /Medical Due to (or as a consequence of): Examiner nous am sionita Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760 Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has b irector, page 2 st 24a. Was an autopsy performed? Yes 2 No 1 Yes r: After this certification of the funeral director, it To the Hospital or Attanding Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☒ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deatl To the Funeral Diractor: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and little of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

CARROLL AVE

TAKOMA

7610

32. Hegistra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Yeer Month **Physician** GLADY 0838 2005 /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE NOPKINS HOSPITAL DOHNS If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Aug. 21 6. Sex 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Country) Virginia 5. Social Security Number **Funeral** 1 ☐ M 2 🗓 F 578-34-9153 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, it a Medical Exertiner must be notified at 1 TyYes 2 □ No Director Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12910 Brunswick Lane 20715 USA Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. filed withIn 72 hours after 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1□Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White Completed by 3 ☑ Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be William Garner Haines Lena Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel R. Ennis / Son 915 Sunset Valley Dr. Sykesville, MD. 20784 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 X Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) permit. Page Department of Important: If any injury or once. Veterans Cemetery 05/16/2005 Cheltenham, MD. 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Lice 6512 NW Crain Hwy. Bowie, MD. 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death eath. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) LAMOU ance letoistor **Physician** mounts /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physicien for use as the buria Completed by Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 1 Yes ≥ No To the Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Tes 2 No Other: Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ē 28a. Date of Injury (Month, Day Yeer) Director: After the in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide within 24 hours after de To the Funerel Directo completely filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier DRIS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOD N. WOLFE HOPKINS AY 1 6 2005 State Registrar

State of Maryland / Department of Health and Mental Hygiene 05 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 12, 2005 **Physician** Year 11:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ft. Washington

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Month, Day Y
November 9 Prince George's Ft. Washington Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 9. 1944 1**x**x M 2□ F Yrs. Director Massachusetts 017-34-2228 Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Maryland Prince George's Ft. Washington 1 Tyes XX No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With ō 12311 Horizon Court 20744 USA Нетs 23a death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Is marked other than "neturel", or iter 1 € Yes 2 □ No 1966— If Yes, Give Year or Dates: 1968 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes XX No Completed by 3 ☐ Widowed 4 ☑ Divorced traumatic event, the Madical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) National Retail Elementary/Secondary (0-12) College (1-4or 5+) Printer 12th Federation h and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname David A. Erickson Emma L. Cashman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12311 Horizon Court Ft. Washington, Maryland 20744 Angela Renee Davis / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Importent: If ite any injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery May 16, 2005 Cheltenham, Maryland ^¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signature of neral Service Licensee 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part 1 Interche disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final M BNOW Physician a lav disease or condition resulting in death) /Medical Que to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events pue to (or as a consequence of) Examiner transit The law requires that the death certificate be executed Mon es of w resulting in death) Last Due to (or as a consequence of attending physician a for use as the burial-P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 1 Yes 2 No 9□ Unknown 9 Unknown been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4XXUnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes XX No To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 Yes 2 No 28a. Date of Injury (Month, Day Year) After th 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation M 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) λq 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 46046 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Mirza-Alikhani Ft. W inton, a land 31. Date filed (Month, Day, Year) Registrar's Signature State 6 Registra

			1 - For State Registrar	State of Man	-			Mental Hy	giene	10122
			Decedent's Name (First, Middle, Last	t)				2. Date of Dea	ath	3. Time of Death
	Physici /Medi		Shirley	Jones	Etz			Month May	12, 200	1.4
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Dear	th	4c. County of De	
			Holy Cross Hospit				Spring		Montg	
п	Funeral		5. Social Security Number 6. S	ex 7.Age (i □M 2027]F	In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		h 9. F	Birthplace (State or Foreign Country)
	Director	Į	402-46-3458 Usual Residence of Decedent		68 Yrs.			April I	7,1937 Ke	entucky
	lend wo		10a. State 10b. County	1	0c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary F sh	ģ	Maryland Montgor	nerv	Gaither	sburg				1X Yes 2 □ No
	r 28s	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	filed within 72 hours after death with the Marylend Hyglene. ther than "netural", or items 23a or 28a-f show that the Medical Examinar must be redified at	Funeral Director	26 Steven Court			2087	7		United St	ates
	deat	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of H		Specify Yes or No-		nerican Indian,
9	or it	교	1 Never Married 2 Married		1955-	1 ☐ Yes 2 ☑ No	Specify:	100.1, 0.0.7	Specify:	1111.6, 610.
21215-0036	ural';	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:	1956					White
5	"net	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wa	orking	16b. Kind of Busine	ss/Industry
12	withly ene. than	텵	Elementary/Secondary (0-12)	College (1-4or 5+)		lousewife	-/		Home	
9	filed Hygi ther ent.	CO	17. Father's Name (First, Middle, Last)	4		Ousewire	18. Mother's Na	me (First, Middle,	Maiden Sumame)	
an	ld be ental ked c	To B	Clarence	E. Jones.	Sr.			Pear1	E. Fultz	•
Maryland	shound M	-	19a. Informant's Name/Relationship (ng Address (Street	and Number or R		r, City or Town, State	
ž	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Depertment of Heelth and Mental Hyglene. Important: if item 27 is marked other than "netural", or items 23a or 28a-f show amounts in the Medical Examination must be notified at order.		David Scholetzky/	Son	13118	Hearthsi	de Lane,	Fairfax	, Virgini	a 22033
Baltimore,	O State		20a. Method of Disposition		20b. Place of Dispo			Date 14,	20c. Location - City	
Ë	Page nent contribute if		1 ☐ Burial 2X☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify		Metropoli		!	005	Alexandri	a, Virginia
alti	mit. ports y inju		21. Signature of Funeral Service Licen		A 22	2. Name and Addre	ss of Facility D	eVol Fun	eral Home	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Δ	80 = 50		Micheal	D. Cell	1/					MD. 20877
8760,	/Medical Examiner bhysician and sthe burial-transit	icai Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Unioritying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a control of the contr	a consequence of):					
.O. Box 6	t the death certif by the attending ached for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ₺ No 9 ☐ Unknown	23c. If yes, outcome of 1 □Live birth 2 [4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	1		23d. Date of o Month	delivery Day Year
rds, P.	quires tha n signed uld be del	by	Part II. Other significant conditions of	ontributing to death but r	not resulting in the u	nderlying cause giv	en in Part I.			to the cause of death? Probably 4XJUnknown
Records,	0 - 0	Completed						24a. Was autop	sy prior t med? death	
Vital	Iclen: Th certificate ector, pag	Be C	25. Was case referred to medical				26 Place of De	1 ☐ Yes		es 2 No
>	di S	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital:	2 ER/Outpatier	nt 3□ DOA Oth	0.00		lence 6 Other (S	pecify)
ion of	ling After fune		27. Manner of Death 1 SNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y		f 28c. Injur Wor			ow injury occurred	
Division	tei or Atters setter de ei Directo	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (- At home, farm, str (Specify)	reet, factory, office		28f. Location (S City or Tow	Street and Number or m, State)	Rural Route Number,
	To the Hospitel or Attend within 24 hours efter death To the Funerel Director; completely filled in by the	Medical		ysician: To the best of r liner: On the basis of ex and manner state	camination and/or in					
	To the comp	Σ	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (Mo	nth, Day, Year)
)	16+1		Vonle	ve, c	WNIE	D	60619		5/12/05	•
			30. Name and address of person who			•			1,54	
-			Connie D. Le, M.D	., 1500 For	est Glen	Road, Si	lver Spr	ing, Mar	yland 209	.0
	્ Sta Regist		31. Date filed (Month, Day, Year) MAY 16	2005 32. Egistrar's	Signature	medi				

State of Maryland / Department of Health and Mental Hygiene [] [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 11, MAY ELSBERG 2005 4:55 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY 5630 WISCONSIN AVENUE, #902 CHEVY CHASE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 🕅 F Months Director 231-18-15<u>9</u>6 NEW YORK Usual Residence of Decedent filad within 72 hours after death with the Maryland Hygiene. show 10b. County 10c, City, Town or Location 10d. Inside City Limits Items 23a or 28a-f shor 1X Yes 2 No MARYLAND MONTGOMERY CHEVY CHASE Direct 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5630 WISCONSIN_AVENUE #902 Funeral 20815 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married ltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: Specify. þ 3 Widowed 4 □ Divorced *natural', WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 3 HOMEMAKER OWN HOME marked othar permit. Pagas 1 and 2 should be fila Department of Health and Mantal Hy Important: If Itam 27 is marked othi any injury or other traumatic event, since 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **JACOB** MAYBELLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STUART M. ELSBERG/SON 303 N. QUEEN ST., CHESTERTOWN, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 □ Cremation 3 🔣 Removal from State

`4 □ Donation 5 □ Other (Specify) FALLS CHURCH, VIRGINIA KING DAVID MEM. GDN. 5/12/2005 21. Signature of Funeral Service Licensee 22 NaTe and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. Jakes | 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20×52 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failing. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS 24 HOURS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed attanding physician and for usa as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. ian/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) Physic 9 Unknown 9 Unknown ģ signad b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificata has b iractor, paga 2 s autopsy perform rmed? 2∰ No 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 No 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Aftar 1 X Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident tha Diractor: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 101 Vom Mb n Luc 9 D22775 MAY 12, 2005 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICK BARR, M.D., 5454 WISCONSIN AVE. #1300, CHEVY CHASE, MD 20815 31. Date filed (Month, Day, Year) 39. Registrar's Signature State 2005

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3 Time of Death 1. Decedent's Name (First, Middle, Last) 5:30 P.M. **Physician** 2005 May Ferguson Ruth Ε. /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street and number) Examiner Prince Georges Heartland Health Care Center-Adelphi Adelphi If Under 1 Yeer If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthdey) 5. Social Security Number 6. Sex Days Hours **Funeral** 1 □ M 2 X F Feb. 16 1932 Virginia 73 579-56-0065 Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23s or 28s-f sho other traumetic event, the Medical Examinar must be notified at Yes 2□No Funeral Director Bowie MD Prince Georges 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number Peges 1 and 2 should be filed within 72 hours after death with 1 nand Health and Mantal Hygiane. nt: If Nem 27 Is marked other than "natural", or Nems 23a or 3 20721 USA 10919 Golf Course Terrace 14. Race - American Indian, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 1 Never Merried 2 Married Specify: Black 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0020 ģ 3 XWidowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Be Completed 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementary/Secondary (0-12) Hecht Co. Mail Room Clerk llth. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Department of Health and Mantal Important: If Item 27 Is marked or any injury or other traumatic eve <u>Annie Ricks</u> George Murrell 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Francine Ferguson/Daughter 20a. Method of Disposition 11913 Wimbleton St. Upper Marlboro, MD. 20774 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, cremetory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5-14-5 Landover, MD. Harmony Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityMarshall's Funeral Home 21. Signature of Funeral Service Licensee 4217 9th. St. N.W. Washington, D.C. 20011 23a. Pent/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Staphylococes Sepsis

Due to (or as a consequence of): Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner End Stuck Renal diseas Examine igned by the attending physicien and be detached for use es tha buriel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of): 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Demention þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? icate has been sig r, paga 2 should b Completed completion of cause of death? 22 No 1 ☐ Yes 2 No 1 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Certification: To 28d. Describe how injury occurred 28e. Date of Injury (Month, Dey Year) 28b. Time of 27. Manner of Death 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 ☐ Could not be determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature end title of certifier 00054566 11/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)
MAY 1 7 2005

DHMH 16 Rev 6/95

low & Sparle

Schitca Bhogaviu, 122 of East Toppa Road, Swit 230, TOWSON MD 21286.
31. Date filed (Month, Day, Year) P. Registrer's Signature

			riease				artment of H				_	10105
		•	For State Registrar	Otato or m	u, y .u	-	tificate of			leg. No.	CUL	18133
			1. Decedent's Name (First, Middle, Last,						2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medic		Carrie F. Farmer						May	15	2005	7:41 PM
	Examin	er	4a. Facility Name (If not institution, give	street and number)				Location of Deat	h		ounty of Death	
			Deer Ridge Manor 5. Social Security Number 6. Se	7. Ac	e (In yrs. la	st birthday)	Rising If Under 1 Year	Sun If Under 24 Hrs.	8. Date of Birth		CÍL 9. Birthr	place (State or Foreign
	Funeral Director]M 2 X]F	8		Months Days	Hours Min.	8. Date of Birth (Month, Day October	10,	1924 Cou	VA
	p .		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	cation					10d. Inside City Limits
	Maryle f sho	5	MD Cecil									1 ☐ Yes 2X No
	128a-	Director	10e. Street and Number		<u> </u> KU	sing S	10f. Zip Code			I0g. Citize	en of What Cou	ntry?
	th with	ai D	1126 Ridge Road				21911			us	A	
	ems erre	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	. 13.	Was Decedent of H	ispanic Origin? (S in, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14	4. Race - Americ Black, White,	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐X If Yes, Give Year or Dates:	No		1 ☐ Yes 2 💢 No				Specify: (u)la	ito
9	be filed within 72 hours after death with the Maryland that Hygiene. od other than "natural", or items 23a or 28a-f show event, the Modical Exercili wit must be motified at	ed t	15. Decedent's Edu	cation		16a. Deced	dent's Usual Occup	ation		16b. Kind	d of Business/In	ite
215	hin 72 9. Marina	plet	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or	5+)	(Give lite. I	kind of work done DO NOT use retired	during most of wo. f)	rking			
2	e filed within al Hygiene. I other than vent, I're Mu	Completed	8			Mush	vroom Gro				lf-Empl	oyed
and	be fill d oth	Be	17. Father's Name (First, Middle, Last) William T. Verno	1					me (First, Middle,		iumame)	
Maryland 21215-0036	should be ind Menta is marked umatic ev	ပို	19a. Informant's Name/Relationship (7)			19b. Mailir	ng Address (Street		. William ura/Route Numbe		Town, State, Zin	c Code)
	d 2 strand trans		Terry Farmer/son	, -, ,) Ebeneze					
Je,	of Heal		20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Name of natory or other place		Date		ation - City or To	
Ē	Page ment of ant: If ury or		1 Burial 2 □ Cremation 3 □ f 1 Other (Specify)	semoval from State		t Not	tingham C	emetery	9-2005		lora, M	
Baltimore,	permit. Pages 1 an Department of Heal important: if item 2 any injury or other once.		21. Signature of Funeral Service Licens	90 7.	1.	22	. Name and Addre	ss of Facility R.	T. Foard	Fun	eral Hor	
	20 = e o		23a. Part . Enter the disease, or comp	John John Sausa	d the death		111 S. Qu				MU 21	911 Approximate
			shock, or heart failure. List only o	ne cause on each I	ine.				c or respiratory an	631,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as			r accu	lent				7 days
	Examiner	П	Commentation that are distinct	b	•	,						
	ם ב	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):						
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):					-	
760,	ysician	caiE		,								
68	ufficate g phy as the									-		
Box	The law requires that the death certificate the has been signed by the attending phyoage 2 should be detached for use as the	Physician/Med	23b. was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth	of pregnan	cy death 3	Ectopic pregnancy	,		23	d. Date of deliv	,
	at the deal by the att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown			Other (specify)				Month	Day Year
P.0	that the ed by detacl		Part II. Other significant conditions co	ntributing to death t	but not resul	ting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco us	e contribute to t	he cause of death?
Vital Records,	ulres l signe	d by	Hyprite.			•	, , ,		1 🗆 Y	es 3	No 3 □ Prol	oably 4 Unknown
cor	w require been si should b	iete	Denont	10					24a. Was			opsy findings available
Re	The lav	Completed	Jerrera						autop perfor	med?	death?	mpletion of cause of 2 No
ita		BeC	25. Was case referred to medical examiner?					26. Place of De	ath (Check only o	10)		
of V	Physician: this certific rai director.	To	1 ☐ Yes 2 ÛNo	fospital: 1 ☐ Inpati		R/Outpatier		4 Trailursing F	Home 5 Resid			(y)
ou c	ling After Tune	ion:	27. Manner of Death Natural 5 Pending	28a. Date of Injui	ay Year)	28b. Time o Injury	Wor	yat k? Yes 2 ⊟No	28d. Describe h	ow injury	occurred	
Division	or Attending Ifter death. Director: After in by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of In	jury - At hon	ne, farm, str	reet, factory, office	103 2 110			Number or Run	al Route Number,
Ö	s after i Dire	Certification:	4 Homicide determined	building, e	tc. (Specify)				City or Tow	n, State)		
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier	sician: To the best	t of my know	ledge, deat	h occurred at the til	me, date and place	e, and due to the o	ause(s) a	and manner as s	stated.
	To the H within 24 To the F complete	Medicai	one)	and manner s			29c. Licens				signed (Month,	
	with To	<	29b. Signature and title of certifier				0.042	4400		-	116105	
7	0		30. Name and address of person who o	ompleted cause of	death (Item	23a) (Tune	Print)	42050		-/	16103	
	3		Prashant Shuk	155.	Park	Sh. i	#400 A	nerdeen	MD 210	01		
	Sta		31. Date filed (Month, Day, Year) MAY 1 7 2005	ompleted cause of	rar's Signati	book	,					
	Regist	rar	#UT1 # F 2003	MARKET !	- 7							

State of Maryland / Department of Health and Mental Hygiene

			State of Ma	arylan	-			lealth a <i>Death</i>	ind M		eg. No.	5	8136
		1. Decedent's Name (First, Middle, Last)			_					2. Date of Dear Month			3. Time of Death
Physici Medic		Phyllis Ju	ne Faz	enba	ker					May 1	7 200)5 ^{Year}	2:15 PM
Examir		4a Facility Name (If not institution, give s Egle Nursing H	street and number) OMC					4b. City, Too Lonad		cation of Death	4c. County Alle		
Funeral		Social Security Number 6. Sex		e (In yrs.	last birthday)	If Unde	r 1 Year Days	If Under	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birthplac	ce (State or Foreign
Director		220-28-7509	M 20XF	73	Yrs.	WORKITO	Juje	110010		June 14		Mary	
P .	1	Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation							I. Inside City Limits
eryle hor	_	3344.52		TOC. OR	y, 10m, 0, 20	oution							1 ☐ Yes 2 ☐ No
₩ 98 8 1 98 1	ecto	Md Allegan 10e. Street and Number	У	Bar	ton_	10f 7i	o Code			1	Og. Citizen of V	Vhat Country	Λ v?
ith with the Merylen 23a or 28e-f ehow unt be notified at	ᅙ	200000000000000000000000000000000000000									United		
filed within 72 hours after death with the Merylend Hygiene. ther than "naturel", or flems 23a or 28e-f ehow ent, the Medical Examiner must be notified at	Funeral Director	19208 Legislat:	LVE Rd 12. Was Decedent I	Ever in U	S 13.1		521 dent of F	lispanic Ori	gin? (Spe	ecify Yes or No-		e - American	
Her d	Ę	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N		1	f Yes, spe	cify Cub	an, Mexican	, Puèrto I	Rican, etc.)	Blac	k, White, etc	c.
a	þ	3. Widowed 4 Divorced	If Yes, Give A Year or Dates:			1 ☐ Yes	2½ No	Specify:			Specify	whit	e
2 hou	2	15. Decedent's Edu			16a. Dece	lent's Usu	al Occup	ation	of worki		16b. Kind of B	usiness/Indu	stry
i a	ple	(Specify only highest grade Elementary/Secondary (0-12)	completed) Coflege (1-4or 5	i+)	life.	DO NOT	onk done Ise retire	during most d)	OF WORK	ng			
d 2 should be filed within 72 hours aft of should be filed within 72 hours aft in end Mental Hyglene. 7 le marked other than "naturel", or treumatic event, the Medical Example.	Completed	12			Home	emak	er				Hon	ne	
be filed ttal Hygie d other event,	Be	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,	Maiden Suman	ne)	
should be and Mental marked o umatic ev	To	Frank Fazenbake	er					Cora					
2 sho end le le m		19a. Informant's Name/Relationship (Ty			19b. Maili	ng Addres	s (Street	and Numbe	er or Rura	d Route Numbe	r, City or Town,	Stete, Zip C	Code)
		Melvin Fazenbak	cer/son	1	19208	3 Le	gis.	lativ	e R	d Bart	on, Md	2152	1
Description of your property of Heel mportant: If Item 2 my Injury or other MCs.		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ R	emoval from State	- 0	Place of Dispo cometery, crei	natory or	other pla		Ĺ,		20c. Location -		n, State
Pag ment ant: I		4 ☐ Donation 5 ☐ Other (Specify)		La	urel H			-	1	20/05 M	oscow, N	Id.	
permit. Pages Department of the Important: If its eny injury or of page.		21. Signature of Funeral Service License						ss of Facilit		ne,111	Charac	- 01	
1 80E 8 9		+ Mayre	Boax		l W	este	rnp	ort.	$^{\rm M}$ d 2	1562		ısı	
		23a. Part1. Enter the disease, or complishock, or heart feilure. List only or	cations that caused ne cause on each lin	the deat	h. Do not en	er the mo	de of dyi	ng, such as	cardiac o	or respiratory arr	rest,	10	Approximate nterval Between
Physician													Onset and Death
/ /Medical		fmmediate Cause (Final disease or condition	Acute 6	FAST	ROIN	FES7	JNI	3L 132	EEF	ING		pri	12 DAY
and the second		resulting in death)		Due to (c	or as a consec	quence or):						ŧ
po iii	Examiner		o		1 < 0			DISI	EASIE			U	NICONN
and al-trar	Xar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (c	or as a consec	quence of):					1	
cate be executed obysicien and the burial-transit	Cal	cause. Enter Underlying Cause (Disease or injury that initiated events)	0 . 1. /.								1	
ficate p phys	₽	resulting in death) Last		Due to (o	or as a consec	uence or						1	
eeth certific attending p	Physician/Me		1										
	<u>S</u>	Part fl. Other significant conditions cor	ntributing to death b	ut not res	ulting in the u	nderlyina	cause di	ven in Part I		23b. Dld to	obacco use co	ntribute to t	the cause of death?
that the dended by the a	hys									101	es 2□ No	3 Proba	ibly 4 Unknow
es that igned t	by P	DIABLISS	MIGLEI) hs									/-
_ = 0 TO	8	DIABETES PERINARAL	ANTE	0.10	Ni	CCA				24a. Was a	an autopsy med?	avail	e autopsy findings lable prior to
iaw requ	Completed		1119 12/	C/ 17 L	_ 1/	5 1315	1/2					of de	pletion of cause eath?
The law ete hes page 2:	E									101	us ax No	10	Yes 2□ No
	BeC	25. Was case referred to medical						26. Place	of Death	h (Check only o	ne)		
Ol VIII Physician: this cartific	10	examiner?	lospital: 1 ☐ Inpatie	ent 2	ER/Outpatie	nt 3 🗆 C	OA Ot	her: 4 Sollu	ırsing Ho	me 5□Resid	ence 6 □Oth	er (Specify)	
a Physical distribution		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	f	28c. Inju Wo	ry et rk?		28d. Describe h	ow injury occur	red	
Attending ar deeth.	atic	2 Accident investigation				М	1]Yes 2□					
OVERIOR Tor Attending after deeth. Director: After din by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injusting, et	ury - At h c. <i>(Speci</i> i	ome, farm, st fy)	reet, facto	ry, office			28f. Location (S City or Tow		ber or Rural	Route Number,
To the Hospital or Attanding Phywithin 24 hours after deeth. To the Funeral Director: After this completely filled in by the funeral	S												A
toep 4 hou uner	edicai	29a. Certifier 1 Certifying Phys (Check only 2 Medical Exami	ner: On the basis of	f examina	wledge, deet ation and/or in	h occurre vestigatio	at the t n, in my	me, date en opinion, dea	d plece, a th occurr	and due to the or red at the time, or	ause(s) and m date and place,	anner as ste end due to t	red. the cause(s)
To the H within 24 To the F complete	Med	29b. Signature and title of certifier	and manner sta	ated.		2	9c. Licen	se number			29d. Date signe	ed (Month, D	ay, Year)
5 ¥ 5 p	-	250. Signature and title of certiller	4								_		
		9th	y				JI	690	7	ſ	1117 18	2 201	2
		30. Name and address of person who or					and	יור ביי	502				
		Harjit Sidhu, 925	BISNOD Wa			weri	and,	Ma ZI	202				
	ate	MAY 2 3	2000	Q = A A A	4.	1	- 0						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 8, 2005 **Physician** Рм 2:41 Gillespie Lorise /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Hospital Cheverly Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | 9. Birthplace (State of Country) | March 20,1959 | Hamlett NC 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex Months 1 M 2 XF 46 245-88-4081 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 √ Yes 2 No Director DC Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20003 1229 G St SE #206 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2K Married Specify: Black 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assembley Line Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Unknown Unknown 19a. Informant's Name/Relationship (Type Print) Continuon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carlton Parks husband 1229 G St SE #206 Washington DC 20003 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt Olivet Cemetery May 16, 2005 Washington DC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lifensee Alexander S. Pope Funeral Home 2617 Penn Ave SE Washington DC 20020 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARDIAC ARRHYTHMIA Immediate Cause (Final FATAL disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🕱 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? DIABETES MELLITUS 24a. Was an autopsy performed? Yes 2 No DISEASE END 2 No STACKE 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide

Examiner that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. sait: If item 27 is marked other then "natural; or Items 23e or 28e-f show

Baltimore, Maryland 21215-0036

7 is marked other then "natural", or items 23e or 28e-1 show traumatic event, the Medical Exactiver must be notified at

permit. Pages 1 Department of H Important: If ite any injury or ot once.

Physician

/Medical

burial-transit

use as the

attending physician

CARRY State Registrar

29a. Certifier

31. Date filed (Month, Day, Year) 7 2005

29b. Signature and title of certifier

3001 HOSPITAL 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LITTLE

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

CHEVERLY MD 20185

6-11-15

State of Maryland / Department of Health and Mental Hygiene | 1 | 5

18138

						C	Certificate of	Death		Reg. No.		10130
П	Physici	an	1. Decedent's Name (First, Middle, Nannie Ma		Corrona				2. Date of De	Day	005 Year	3. Time of Death 2:15 AM
4	/Media	cal	4a. Facility Name (If not institution,		Gowans			4b. City, Town, or I	May 1			
Ĺ	Examir	ner	Egle Nursing		ioer)			Lonaconi	ng		County of Death	
	Funeral Director		214-14-7406	3. Sex 1 □ M 2 X DF	7. Age (In yrs. la 87	ast birtho	Months Days		8. Date of Bin (Month, Da Feb. 23	th y, Year) 3 , 1 9	9. Birth Cou 918 Mar	pplace (State or Foreign Intry) Cyland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Citv	. Town o	r Location					10d. Inside City Limits
	e Maryl	ctor	MD Alleg	any			Cresaptown					XXYes 2□No
	th with th	al Dire	13717 Cecil	Ave.			10f. Zip Code 2150	02		_	ited Sta	-
020	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "neturel", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be mailled at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	Armed Fore	2√21 No 9	S	13. Was Decedent of If Yes, specify Cub 1 ☐ Yes ※XXNo		pecify Yes or No o Rican, etc.)		14. Race - Amer Black, White Specify: Whi	, etc.
5-0	72 h	eted	15. Decedent's (Specify only highest	Education grade completed)		16a. D	ecedent's Usual Occupione kind of work done fee. DO NOT use retire	pation during most of wor	king	16b. Ki	nd of Business/I	ndustry
Maryland 21215-0020	d within giene. r then	Completed	Elementary/Secondary (0-12) unknown	College (1-	4or 5+)	`li	fe. DO NOT use retire Nurses A			Nui	rsing Ho	ome
2	e file al Hyg othe	Be C	17. Father's Name (First, Middle, La	ist)				18. Mother's Nan	ne (First, Middle,	Maiden	Sumame)	
yla	ould b Ment arked	To I	Ellis	Dye				Ella	Fo	outz		
Mar	nd 2 sh aith and 27 is m r traum	n n	19a. Informent's Name/Relationshi Judith Johnson/				Box 143,			_	r Town, State, Zi 21521	ip Code)
Baltimore,	Pages 1 e ent of Hea nt: if item ny or othe		20a. Method of Disposition 1 ☐ Burial 2√5 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			ace of D metery,	isposition (Name of crematory or other pla	ice)	Date 05/17/ 2005	20c. Lo	cation - City or T perland	own, State Maryland
Balti	permit. I Departm Importar any inju		21. Signature of Funeral Service Li		10	7	22. Name and Addre	ess of Facility	Boal Fur			nd 21562
			23a. Part1. Enter the disease, or co	omplications that ca	used the death.	. Do not					, ar y rain	Approximate Interval Between
	Physician /Medical		shock, or heart failure. List or Immediate Cause (Final disease or condition	nly one cause on ea	ch line.	.5:	lroke				; ! !	Onset and Death
	Examiner		resulting in death)	a	Due to (or		nsequence of):					
ox 68760,	The law requires that the death certificate be executed ate has been signed by the ettending physician and page 2 should be deteched for use as the burial-transit	/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Нурcd		as a cor	Curshransequence of):	Vascu	lar D	-iSe	ase	15 min
<u> </u>	death	iclar	Part II. Other significent conditions	e contributing to do	th but not rocu	ltina in th	o underlying souse si	von in Dart I	22h Did 6	labone	uno contributo i	to the ceuse of death?
<u>Р</u> .	d by the	by Physiclan/					-	6				obably 4 1 Unknown
Division of Vital Records, P.O. Bo	requir been s should	Completed by	Congestive	· Dia	bete	S	mallitis	·	24a. Was perfo	an autop rmed?	a o	Vere autopsy findings vailable prior to ompletion of cause f death?
ž	The la	mo							101	res 28	No 1	□Yes 2□No
/ita	sian: ertifica ector.	Be	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only o	ne)		
 	hysic this co	၉	1 ☐ Yes 2 ☑ No 27. Manper of Death		patient 2 E		Ment 3L DOA		ome 5 Resid			ify)
on	ath. :: After e funer	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of (Month)	, Day Year)	28b. Tim Inju	ry Wo	ryai rk?]Yes 2 □ No	28d. Describe h	iow injur	у осситеа	
Divis	al or Atter s efter des l Director od in by th	Certification:	3 ☐ Suicide 6 ☐ Could no determin	200. FIACE C	of Injury - At hor g, etc. (Specify,	ne, farm	, street, factory, office		28f. Location (S City or Tox	Street and vn, State	d Number or Rui)	ral Route Number,
	To the Mospital or Attending Physician: The law within 24 hours efter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier 1 Certifying (Check only one)	Physicien: To the base eminer: On the base and manner	sis of examinati	rledge, d on and/c	eath occurred at the ti r investigation, in my o	me, date and place opinion, death occu	, and due to the cred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the To the Corner	ž	29b. Signature and title of certifier	SIC	11 .	λ ,	29c. Licens			29d. Dat	e signed (Month	470
	3		30. Name and address of person w	no completed cause	of death (Item	23a) (Ty	pe, Print) Frostk) 14469 ourg, Mar		21532	/ //	005
	Sta	to	31. Date filed (Month, Day, Year)	,	gistrar's Signat	ure		J.				
	Registr		MAY 1	8 2005	Angua.	B	Sparke					

Jarvis Green 05-03077 dl

			1 - For State Registrar	State of Maryland /		Health and M	Mental Hyg	-	18139
			1. Decedent's Name (First, Middle, Last)				2. Date of Deat		3. Time of Death
	Physici /Medio		Jarvis	Green			May 3,	Day Year 2005	7:38 P M
	Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town	, or Location of Death		4c. County of Death	1
и			7267 Wood Hollow 7	Terrace	Fort Wa	ashington		Prince Ge	eorge's
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bi	rthday) If Under 1 Ye	ar If Under 24 Hrs.	8. Date of Birth (Month, Day, 08/28	Year) 9. Birth	place (State or Foreign
	Director		246-50-7181	68	Yrs.		08/28	/36 N.C	arolina
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	vn or Location				10d. Inside City Limits
	f sho	ō	MD Prince (Seorges Fort	Washing	ton			Y☐Yes 2 ☐ No
	1388 The	rect	10e. Street and Number	101	10f. Zip Code		11	Og. Citizen of What Cou	untry?
	3a or	ā	1108 Windemere	Court		20744		U.S.A	•
	ours after death with the Marylan rai', or items 23a or 28a-f show Exaciliner and be notified at	Jere	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of	of Hispanic Origin? (Spuban, Mexican, Puerto	pecify Yes or No-	14. Race - Amer	
9	or ite	Ē	1 ☐ Never Married 2 X Married	Armed Forces? 1X Yes 2 □ No If Yes. Give	1 ☐ Yes 2 🛣		Hican, etc.)	Black, White	
93	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ta Madeal Examinat cust be multisd at	Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: 1963	10105 204	чо зресну.		Specify:Bla	ick
5	72 h 'natu	ete	15. Decedent's Edu (Specify only highest grade	cation 16a e completed)	 Decedent's Usual Oct (Give kind of work do.) 	cupation ne during most of worl ired)	king	16b. Kind of Business/li	ndustry
121	within iene. than	ш	Elementary/Secondary (0-12)	College (1-4or 5+)	Milk Pro			Private	
2	iled tygi ther nt, 1		17. Father's Name (First, Middle, Last)		TITTE TEO		ne (First, Middle, N		,
au	d be	Be c	Zeno	Green		Kizz		Elliott	
Maryland 21215-0036	2 should be f and Mental H is marked of aumatic eve	스	19a. Informant's Name/Relationship (Ty)		b. Mailing Address (Stre				in Code)
Z S	and 2 sealth an n 27 is		Frances Green		-				MD 20744
ē,			20a. Method of Disposition	20b. Place o	of Disposition (Name of ary, crematory or other p	alace)	Date	20c. Location - City or T	Town, State
Ë	Page nt: If ry or		X Burial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify)		ltenham	5	5/12/05	Cheltenha	m, MD
Baltimore,	permit. Pages. Department of the important: If ite any injury or of once.	16	21. Signature Juneral Service License	ее				fessional	
m	8 9 E 6 8		Thene O.	Phlips	3605 14	th St., N	W Washi	ngton, DC	20010
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	ications that caused the death. Do	not enter the mode of o	tying, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	HUDOLAFOINE OF	Herosdorone	CARDIGUASUS	DAY DITEA	in	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence			y v		
	LXaiiiiiei	L	Sequentially list conditions,)	0				
	pe psit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	or):				
	and and ul-tran	хап	that initiated events resulting in death) Last	Due to (or as a consequence	of);				
1760,	te be executed ysician and ne burial-transit	icai E							
687	e			J					
Вох	death certifica e attending ph of for use as th	N/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy				23d. Date of deliv	very
		icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal death	h 3 □Ectopic pregna 5 □ Other (specify)			Month	Day Year
P.0	t the by th tache	Physician/Med	9 Unknown	9□ Unknown					
S,	es tha gned be de	ру Р	Part II. Other significant conditions cor	ntributing to death but not resulting	in the underlying cause	given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Record	w require been sig should t						1 □ Ye	s 2 No 3 Pro	bably 4 Munknown
ecc	e law r has be ge 2 sh	pie					24a. Was ar	y prior to c	opsy findings available ompletion of cause of
 		Completed					perform Yes 2	ied? death?	2 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lahal.			th (Check only on	3)	
of	Phys this al dii	은	1 A 163 2 140	tospital: 1 ☐ Inpatient 2 ☐ ER/O	dipatient 3 DOA			nce 6 XOther (Spec	ify) scene
	ding l h. After funer	ion	27. Manner of Death 1 Natural 5 ☐ Pending		Time of Injury W	Vork? □ Yes 2 □ No	28d. Describe ho	w injury occurred	
Division	i or Atteno after death Director: I in by the	licat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, f			28f. Location (St	reet and Number or Rui	ral Route Number
Θ	after after Dire	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	and, chook, ideally, and		City or Town	, State)	,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.		29a. Certifier 1☐ Certifying Phys	sician: To the best of my knowledg	e, death occurred at the	time, date and place,	and due to the ca	use(s) and manner as	stated.
	he Ho in 24 he Fu pletel	Medicai	(Check only 2 Medical Examination)	ner: On the basis of examination a and manner stated.	nd/or investigation, in m	y opinion, death occui	rred at the time, da	ite and place, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	1		ense number MF,	25	d. Date signed (Month	, Day, Year)
	000		P V	W. Chi			M	ay 4, 2005	
	ac		30. Name and address of person who co	A A A A A A A A A A A A A A A A A A A	144 D	nn Street	Raltimo	ore, Maryla	nd 21201
			31. Date filed (Month, Day, Year)	Mc (N) M	11).	Ini Delect	DOTETH	ralyla	1101 21201
	Sta Registi		MAY 1 6 2005	32. Registrar's Signature	e e				

			1 - For State Registrar		Maryland		artmen rtificate			and M	,	Reg. No.	000		8140
	Physici /Medi		1. Decedent's Name (First, Middle, La Walter		issinge	er					2. Date of Dea	ath Day	15 2	3. COS 7	Time of Death
	Examir		4a. Facility Name (If not institution, gir		. 1				Location of				County of D		
			Washington Co	_ _		na brimah utawa	Ha If Under		stow If Under:		0.000		lashi		
п	Funeral Director			1 M 2 □ F	7. Age (In yrs. Ia: 68	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da) 9 / 4 / 1 9	v, Year)	9.	Country)	(State or Foreign PA •
	p		Usual Residence of Decedent								3/4/13	30			ra•
	death with the Maryland ms 23a or 28a-f show r must be notified at	_	10a. State 10b. County		10c. City,	Town or Lo	cation								nside City Limits
	8a-f	Funeral Director	PA. Fulto	n		McCo	onne1		urg						Y∏Yes 2 □ No
	with t	ā	10e. Street and Number				10f. Zip		7000			10g. Citi	izen of Wha	t Country?	
	heath	era	286 Horton	Drive	dent Ever in U.S.	. 13.	Was Deced		7233 spanic Orie		ecify Yes or No-		USA 14. Race - A	American In	ndian.
36	ges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiene. If item 27 is marked other than "natural; or items 23s or 28s-f show or other traumatic avent, the Middeal Examiner must be notified at	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed For 1 XYes If Yes, Give Year or Da	ces? 2 □ No		lf Yes, spec 1 □ Yes			, Puerto	ecify Yes or No- Rican, etc.)			Vhite, etc.	
21215-0036	2 hou atura	Completed by	15. Decedent's E	ducation		16a. Dece	dent's Usua	d Occupa	tion			16b. Ki	ind of Busine	ess/Industr	y
215	within 7 ene. than "n	Jple	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-	4or 5+)	(Give life.	kind of wor DO NOT us	rk done d se retired;	luring mosi)	of work	ing				
	filed wi Hygien ather th	Con	12	4+3		Fam	lly_	Den	tist				alth		
and	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Las	•							(First, Middle,				
Maryland	2 should be filed within and Mental Hygiene. is marked other than sumatic avant, the Ms	1º	A. Wilbur G	rissing	ger	10h Maili	ag Addross	(Street o		ula	R . al Route Numbe		erts	an Tin Cond	-1
Ma	id 2 s ith an 27 is i			inger/	aife						onnell			-	•
ē,	f Healitem		20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Nan	ne of	1		Date		cation - City		
Ë	Pages ent of nt: if if		1 ☐ Burial 2 Marcremation 3 [14 ☐ Donation 5 ☐ Other (Speci				natory`or or urgCr			5/2	1/05	Smi	thsb	urg,	Md.
Baltimore,	permit. Page Department of Important: if any injury or once.	1	21. Signature of Funeral Service Lice	1.1	mo103	22	2. Name an	d Addres	s of Facilit	y MoW	ard L.	Sip	es F	unera	alHome ,Pal723
8760,	death certificate be executed Medical e attending physician and dior use as the burial-transit	Ical Examiner	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	aDue to (c	or as a conseque	nce of):	atip	le	M	We.	lom			Inte Ons	roximate rval Between et and Death
.O. Box 6	death certific e attending p d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		th 2 Fetal d int at time of dea	eath 3	Ectopic pro					2	23d. Date of Month	delivery Day	Year
rds, P	The law requires that the ste has been signed by the bage 2 should be detache	ed by P	Part II. Other significant conditions	contributing to de	ath but not result	ing in the u	nderlying ca	ause give	n in Part I.		23e. Did to	\	Jet .	te to the cau] Probably	use of death?
I Records,	The lar ate has page 2	Completed by	- Pancy	talpe	nic	\		_			24a. Was a autop perfor	sy .	24b. Were prior death	to complet h?	indings available ion of cause of
Vital	Physiclan: this certific ral director,	Be	25. Was case referred to medical examiner?	Manager N. d.						of Death	(Check only o	ne)			
of	Physi this c	<u>유</u>	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Xin		NOutpatier 8b. Time of		_	4 🔲 Nui		me 5 Resid			Specify)	
UO	ding f h. After funer	ton	1 Natural 5 Pending	(Month	, Day Year)	Injury	M	8c. Injury Work	aı ? ′es 2.∐l		28d. Describe h	ow injury	у оссигва		
Division of	Attending or death. ector: After by the fune	flca	3 Suicide 6 Could not b	28e. Place o	of Injury - At hom	e, farm, str			03 20.		28f. Location (S	treet and	d Number o	r Rural Rou	ite Number.
Ö	after after Dire	Certification:	4 Homicide determined	buildin	g, etc. (Specify)						City or Tow	n, State))		
	To the Hospital or Attenc within 24 hours after deatt To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one) Certifying Pl	hysician: To the I miner: On the ba and mann	sis of examinatio	edge, deatl n and/or in	occurred a	at the time in my op	e, date and inion, deat	d place, h occurr	and due to the ded at the time, o	ause(s) late and	and manne place, and	r as stated. due to the o	cause(s)
	To the Withir To the comp	Me	29b. Signature and title of certifier	40			29c	License	number	1	46473	29d. Date	e signed (M	onth, Day,	Year)
			30. Name and address of person who	completed cause	of death (Item 2	(Type,	Print)		11	2	1		, 1	2	0.20
H	20+1		Hind Han	idan	· WD:	1130	(C	Ago	L (T	Had	peno	rwot	M	21740
	Sta Registi		31. Date filed (Month, Day, Year)	2005 32. Rg	istrar's Signatur		perte	,			/)			

		4	For State Registrar		State o	of Mary	/land / I	-	rtment o			nd Me	ental Hyg	giene	05	18141
			Decedent's Name (First, Middle	e, Last)									2. Date of Dea		V	3. Time of Death
	Physicia		Gloria	Ro	berta	L	Golds	mith	1				Month May	9, 2	005 Year	2:14P M
	/Medic Examin		4a. Facility Name (If not institution						4b. City, To	wn, or L	ocation of	f Death			ounty of Dea	ath
	Examin	er	Montgomery Ge				1		Olne	У				М	ontgo	nery
	Eunoral		5. Social Security Number	6. Sex			n yrs. last bi	rthday)	If Under 1 \	ear	If Under 2		8. Date of Birt (Month, Da	h (Vear)	9. Bi	rthplace (State or Foreign
	Funeral Director		119-16-5113	1 🗆	M 2 ⊠ F	79	9	Yrs.	Months D	ays	Hours	Min.	CT. 15	192	5 N	ew York
			Usual Residence of Decedent													1
	ylan	. 1	10a. State 10b. County			11	oc. City, Tov	vn or Loc	ation							10d. Inside City Limits 1 XYes 2 □ No
	Ma	į	Maryland Montg	omer	У		Si1	ver	Sprin	g						
	1 th	Director	10e. Street and Number						10f. Zip Co	ode				-	n of Whal C	
	th will		15101 Inter1	ache	n Dri	ve	Apt.	303		0906						es of America
	dea dea	Funerai	11. Marital Status	1:	2. Was Dec Armed F	edent Eve orces?	er in U.S.	13. W	as Deceden Yes, specify	t of His Cuban	panic Orig , Mexican,	gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)	. 14	Black, Wh	nerican Indian, nite, etc.
9	or it	F	1 Never Married 2 Mar		If Yes, G	2 X No ive		1	□Yes 2/] No	Specify:			s	pecify:	White
8	be filed within 72 hours after death with the Maryland at Hygiene. A let Hygiene death with the Maryles and content than "natural", or items 23a or 28a-f show event, the Madical Exeminar must be notified at	d by	3√ Widowed 4 □ Divorce		Year or [Dates:	1		and the second		line.			16h Kina	f of Busines	o/Industry
5	72 h	Completed	15. Deceder (Specify only higher	nt's Educ st grade	atio n co <i>mpleted)</i>)	168	(Give k	ent's Usual C and of work of ONOT use	done du	iring most	of working	g .	TOD. NITE) Of Busilies	samoustry
12	within ene. than	ш	Elementary/Secondary (0-12)		College ((1-4or 5+)	1	_		,				Inita	d Sta	tes Governmen
2	lled v Hygie her t		12 17. Father's Name (First, Middle)	(ast)				Seci	retary		18. Mothe	r's Name	(First, Middle,			ces Governmen
ä	12 should be filed within h and Mental Hygiene. 7 is marked other than " traumatic evant, traina	Be	Julius Aarons								Ros	e Di	ckman			
Ž	d Me d Me nark natic	ို	19a. Informant's Name/Relation		Print)		19	h Mailin	Address /S	Street at			Route Numbe	er, City or	Town, State	, Zip Code)
Maryland 21215-0036	12 sl h an 7 ls r traur		Leslie A. Golds			n										ey 08844
e,	Healt Healt		20a. Method of Disposition				20b. Place	of Dispos	ition (Name	of	-		ate			or Town, State
ŏ	S to F S		1 TBurial 2 ☐ Cremation	3 X Re	moval from	State			atory or othe)5/12	/05	C+	Alban	s, New York
ŧΪ	t. Parturant		' 4 ☐Donation 5 ☐ Other (01d M									
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If tlam 27 is marked any Injury or other traumatic a once.		21. Signature of Funeral Service	7	Office	tit.		Pa	Trans	ky	Go 1 db	jerg Pike	Memori , Rock	al Ch	apel,	20852
	40140		23a. Part1. Enter the disease, of	r complie	ations that	caused th	e ceath. Do								,	Approximate
			snock, or near failure. Lis	t only on	e cause on	each illie.	ZN 57									Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a						2 676	£					20115
	/Medical Examiner		,	1	Due to	o (or as a o	consequence	9 of):								
		<u>_</u>	Sequentially list conditions,	b	Due to	o (or as a	consequence	e of):								
	ed sit	nj.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	≺			·									
	be executed ician and burial-transit	xar	that initiated events resulting in death) Last	C.		o (or as a	consequence	e of):						- 11 -		
8760,	cate be executed oblysician and the burial-transit	Physician/Medical Examiner		M.												
687	certificate nding phys ise as the	dic		-0												
×	res that the death certifics igned by the attending pt be detached for use as t	/Me	IF FEMALE: 23b. Was decedent pregnant	2:	3c. If yes, o	utcome of	pregnancy							23	3d. Date of c	felivery
Вох	death of atten	ciar	in the past 12 months?				Fetal dea		Ectopic pred Other (spec						Month	Day Year
o.	the d y the ched	iysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unk	nown										
<u>α</u>	requires that the een signed by th nould be detache		Part II. Other significant condit			death but	not resulting	in the ur	ndertying cau	ise give	n in Part I		23e. Did 1	obacco us	e contribute	to the cause of death?
ds	uires 1 sigr 1d be	d b	HUPERTENS	ZOM	·								10	Yes 2	No 3□	Probably 4 □Unknown
Ö	~ Q 70	Completed by											24a. Was		24b. Were	aulopsy findings available
Re	The law ate has b page 2 sl	E G												psy ormed? 2 No	death	o completion of cause of es 25No
a	ilcian: Th certificate rector, pag	e Co	25. Was case referred to medic	al							26 Place	e of Death	1 ☐ Yes			03 20110
₹	Physician: this certific ral director,	8	examiner?		ospital:	Innation	2 🗆 ER/0	Outnatien	t 3 🗆 DOA	Othe			ne 5□Res		□Other (S	pecify)
Division of Vital Records,	Phys r this sral dii	: To	27. Manner of Death			e of Injury		. Time of		c. Injury Work			28d. Describe			
On	ding I th. After funer	tion	1 ☐Natural 5 ☐ Pend 2 ☐ Accident inves	ing tigation	(MC	ontn, Uay	rear)	Injury	м		Yes 2	No				
/isi	Attanding r death. actor: After by the fune	fica	3 ☐ Suicide 6 ☐ Coul	d not be mined	28e. Pla	ce of Injur	y - At home, (Specify)	farm, str	eet, factory,	office				Street and wn, State)	Number or	Rural Route Number,
D	after after din b	Certification:	4 Homicide		Duli	iding, etc.	(Specify)						Only or 10	, O.a.o,		
	To the Hospitel or Attending Ph. Within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	alc	29a. Certifier 1 ☐ Certify	ing Phys	sician: To t	he best of	my knowled	lge, death	n occurred a	the tim	ne, date ar	nd place,	and due to the	cause(s)	and manner	as stated. due to the cause(s)
	a Ho 1 24 h	ledical	(Check only 2 Medica one)	ıl Examıı	ner: On the and ma	basis of e anner state	ed.	and/or in	vestigation, i	n my op	oinion, dea	atn occurr	ed at the time,			
	To the withir To the comp	Me	29b. Signature and title of certif	ier		AR-M -					number				-	onth, Day, Year)
	15) Frank of	120	Dr.	Um			12	123	630			13/	17 9,	2005
							ath (Item 23a	a) (Type,	Print)	1		2 1	1077	CAL		MD 20877
			FRANK J. MA	10, 1	no 1	6226	FREE	OERZ	ch 1	EUA.	n F.	113.	0112111	ERSB	UKO,	
		ate	31. Date filed (Month, Day, Yea	r)	32	egistrar	's Signature	A	alles							
	Regis	trar	MAY 1	6 21	105	Delive	10	14								

			For State Registrar	State of Maryland	-	artment of F		Mental Hy	giene 05	18142
-4	A 10-1		1. Decedent's Name (First, Middle, Last,					2. Date of De	eath Nav Year	3. Time of Death
н	Physicia /Medic		Joann Laura	Harris				MAY	10, Day 2005	1829 M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death	1	4c. County of De	ath
			Prince George	's Hospital		Che	verly		Crince	6 erges
	Funeral		5. Social Security Number 6. Se			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	rth 9. B	irthplace (State or Foreign Country)
	Director		370 10 0300	M 2√F 70	Yrs.			Feb.	1, 1935 W	lash. D.C.
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or L	ocation				10d. Inside City Limits
	Many!	jo	Maryland Prince	George For	estv	ille				1 Yes 2 □ No
	28a	rect	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?
	3a or	D	5507 Marlboro	Pike #3		20747			United S	tatos
	death ms 2	Jera	11. Marital Status	12. Was Decedent Ever in U.S	. 13.	Was Decedent of H	lispanic Origin? (S)	pecify Yes or No		nerican Indian,
9	after or Ite	by Funeral Director	1 Never Married 2 Married	Amed Forces? 1 ☐ Yes 2 🔼 No If Yes, Give		1 ☐ Yes 2X No	Specify:	nican, etc.)	1	Black
8	rel',	d by	3 ⊠ Widowed 4 □ Divorced	Year or Dates:					Зреспу:	JIACK
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or Items 23a or 28a-f show the Medical Examinational be notified at	Completed	15. Decedent's Edu (Specify only highest grad		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wor	king	16b. Kind of Busines	s/Industry
12	within ne. hen	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)			2)			
	Hygie Hygie ther t	ဝိ	17. Father's Name (First, Middle, Last)		DISI	atcher	18. Mother's Nam	ne (First, Middle	Federal Maiden Sumame)	Govt.
au	d be i	Be c	Harry Evans					Piers		
Maryland	shout nd Me mark	P_	19a. Informant's Name/Relationship (T)	rpe, Print)	1 <u>9</u> b. Maili	ng Address (Street				Zip Code)
S	nd 2 stith at 27 is r trau		Louis Harris, I	II/Son	550 Fore	Marlbo	ro Pike	0747	er, City or Town, State,	
je,	s 1 a f Hea item othe		20a. Method of Disposition		ace of Dispe	osition (Name of matory or other place		Date	20c. Location - City of	
Ë	Page sent o nt: If ry or		1 ☐ Burial 2 【XCremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)	temoval from State Mo+	ropo]	itan Cr	em. 5/1	8/05	Alexandr	ia, VA
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury or other traumatic event. Its Madical Examinat must be notified any once.		21. Signature of Funeral Service Lices	98 A DC S	2	2. Name and Addre	ss of Facility	e Fune	eral Home:	q
<u>m</u>	90 E # 9		Vul Cara	no olviv	J 5	38 Marl	boro Pk	/Fores	stville,	MD 20747
П	- 1		23a. Part 1: Erter the disease, or complishock, or heart failure. List only o	ications that caused the death. ne cause on each line.	Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory a	arrest,	Approximate Interval Between
Į,	Physician		Immediate Cause (Final disease or condition	Atherosele	votic	Cardio	vascula	n Itea	it Diseas	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):					
В	Lamine	L	Sequentially list conditions,	b. Due to for as a consecu	sans offi					
	ped nsit	Examiner	Sequentially list conditions, if any, leading to infline date cause. Enter Underlying Cause (Disease or injury	State (or as a normal tr	airikia iorgi					
	xecu and al-tra	хаг		Due to (or as a consequ	ence of):					
68760,	death certificate be executed e attending physician and od for use as the burial-transit	calE		4						
687	ificate g phy as the			U						
Вох	leath certifica attending ph i for use as th	Z/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar		75			23d. Date of d	elivery
œ.	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of de		Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	at the by th	Physician/Med	9 Unknown	9□ Unknown						
	The law requires that the der ate has been signed by the a page 2 should be detached fo	by F	Part II. Other significant conditions co	ntributing to death but not resu	ting in the u	inderlying cause giv	en in Part I.		tobacco use contribute	
ord	w requir been si should I	ted						1	Yes 2□No 3□I	Probably 4 @Unknown
Records,	e law r has be je 2 sh	Completed						24a. Was	psv prior to	autopsy findings available completion of cause of
= =	The cate h	Con						perf 1 ☐ Yes	ormed? death? 2 No 1 □ Ye	
/ita	cien: ertific	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Dea			
of Vital	Physicien: r this certific ral director,	٦.	1 Yes 2 No	1 Inpatient 2	R/Outpatie 28b. Time o	III JUON	di ballater i i		idence 6 Other (Sp how injury occurred	pecify)
UQ	ding h. After funer	tion	1 ■ Natural 5 □ Pending	(Month, Day Year)	Injury	Wor	k? Yes 2 □ No	200. 0000.100	nov injury observed	
Division	Attending r death. ector: After	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hor	ne, farm, st				Street and Number or I	Pural Route Number,
<u>S</u>	after after Direct d in by	Certification;	4 Homicide	building, etc. (Specify,				City or To	wn, State)	
	Hospitel or 24 hours afte Funerel Dir stely filled in			sician: To the best of my know						
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medicai	(Check only 2 Medical Exami	ner: On the basis of examinati and manner stated.	on and/or in			rred at the time,		
	To the within 2 To the complex	Σ	29b. Signature and title of certifier	11.04		29c. Licens			29d. Date signed (Mor	nth, Day, Year)
			falvedor /	moster, &	>	/<	1003597	-/	MAY 11,	ros
2	(6)		30. Name and address of person who c		/	Print)	too559) re, Cho	0.1	1100 /0	Cal
112			SALVAdur Sylve	31 3/ 3001	rospi i	tal Driv	ve co	my.	MARYING	~ ((
	Sta	to	31. Date filed (Month, Day, Year) MAY 1 7 2005	M. Registrar's Signat	ure					

			For State Registrar		State	of Ma	aryland	-	artment <i>tificate</i>				ental Hy	gien Røg. N	2 U L)5	18143
			Decedent's Name (First, Middle, Last)											3. Time of Death			
	Physicia /Medic		Mark C. Ho	lmon									lay	12		2005	10:45 A M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Locat								of Death			c. County			
			Cresent Cities						Riverdale				P	Prince Geo		rges	
	Funeral Director	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1						st birthday) Yrs.	If Under 1 Months	1 Year If Under 24 Hrs. Days Hours Min.		8. Date of Bir (Month, Da 12-15-	th ay, Yea -196	ar) 9. Birthplece Country) New Yor			
	D .	Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location							10d. Inside City Limits							
000	anyla shov										1 Yes 2 □ No						
	286-f		10e. Street and Number 10f. Zip Code								10= 0	Citizen of V	40				
	a or		611 Maury Ave					20745						S.A.	Wildle Coul	iti y r	
	eath		11 Marital Status 12. Was Decedent Ever in U				ver in U.S.	13.1	Was Decedent of Hispanic Origin? (Spec			city Yes or No			can Indian,		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other treumatic event, the Medical Eventral revel be notified at once.	þ	Armed Forces? 1 ☒ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ N 1 ☐ Yes, Give Year or Dates:			orces? 2 K) N ive		'	Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2X No Specify:			Rican, etc.)		Black, White, etc. Specify: Black			
5	2 ho	Completed	15. Decedent's Education 16a. D. (Specify only highest grade completed) (G					16a. Deced	ecedent's Usual Occupation				16b.	Kind of Bu	usiness/în	dustry	
7	thin 7 e. "n	pie	Elementary/Secondary (0-12) College (1-4or 5+)				(Give kind of work done during most of working life. DO NOT use retired)				ng						
7	er th	Con					Eng	ngineer						Priva			
2	be file ta! H) d oth	Be	17. Father's Name (First, Middle, Last)										irst, Middle, Maiden Sumame)				
7	Men Men arke	2	Marca C. Holmon						Elizabeth Durham								
Dallillore, Mar	and 2 shi alth and 1.27 Is m or troum		19a. Informant's Name/Relationship (Type, Print) Elizabeth D. Holmon/Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Ziji 2415 March Rd Eden, Newyork 14057							State, Zip	Code)						
	ages 1 ant of He int: If item y or other		Durial 21 Cremation 3 Removal from State						e of Disposition (Name of etery, crematory or other place) rdale Crematory 5-17-05 Riverdale,								
	orter		21. Signature of Funeral Service		90						-		lenkins			-	
ŏ	Depar Impor any ir)	4		-		74	74 Lar	ndov	er R	d Lar	ndover,	MD	2078	35	
	Physician /Medical Examiner		shock, or heart failure. List only one cause on gach line.									Approximate Interval Between Onset and Death					
,00,0	icate be executed physician and s the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that intilated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):														
00	icate phys s the	dicai															
O. DOX o	w requires that the death certifibeen signed by the attending should be detached for use as	Completed by Physician/Me						Ectopic pregnancy Other (specify)					23d. Date of delivery Month Day Year				
ř	that led by deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use cont								ntribute to the cause of death?						
2	fhe law requires te has been sigr age 2 should be		Caesal Decubitus Sepsis							1 🗆	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown						
ecolus,									24a. Was								
C										10			auto perfe	performed? death?		death?	mpletion of cause of
ומ א	en: tifica tor. p	0	25. Was case referred to medical 26. Place of Death (Check only one)									2010					
	ysici is cer direc	OB	examiner? 1 ☐ Yes 2 No	Н	lospital:	Inpatie	nt 2 El	R/Outpatien	t 3 DOA	Othe					6 □Oth	er (Specif	v)
0	ng Ph ter th	T:uc															
DIVISION	andir.	atic	2 Accident investigation M 1 Yes 2 No Suicide Accident A														
	To the Hospitel or Attending Physicien: The law requires that the death certif within 24 hours atterdeath. Within 24 hours atterdeath. To the Funeriel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification:								28f. Location (City or To	ution (Street and Number or Rural Route Number, or Town, State)						
		edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
	To t withi To tl	W	29b. Signature and title of certifier DY8213 29d. Date signed (A DY8213														
R	(5)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aug landerestills MD 20784.								20784						
	Sta Registr		31. Date filed (Month, Day, Year MAY 1 7		3 Re	Registra	ar's Signatu	re dra	de)								
			MILLI T		100		-	1									

			, roi	partment of Health and Mertificate of Death		ene 0 0 5	18144						
	Physici	20	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year 3. Time of D									
	/Medic		Nina Jean Hill		May 1	12 2005 1900 M							
	Examin Funeral Director	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death								
			Harford Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd)	Havre de Grace Havre de Grace Havre de Grace Havre de Grace Havre de Grace	e 8. Date of Birth	Harford							
			212-62-7658 1 M 2 M F 79 Yrs	Months Days Hours Min	(Month, Day, Dec. 28	elace (State or Foreign htry) irqinia							
			Usual Residence of Decedent										
	how		10a. State 10b. County 10c. City, Town or	Location		1	0d. Inside City Limits						
	Ba-f-s	cto	Maryland Cecil	Perryville			1K Yes 2 No						
	it th or 28	Dire	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cour							
	s 23a	rai	400 Carter Court, Apt. D	21903		U.S.							
36	within 72 hours after death with the Maryland ane. then "naturel", or items 23a or 28a-f show ta Medical Examinar nast be nutified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No ☐ If Yes, Give	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto □ Yes 2 No Specify: 	ecry Yes or No- Rican, etc.)	14. Race - Americ Black, White,							
21215-0036	turei'	q pe	3 ☑ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. De	cedent's Usual Occupation	1	6b. Kind of Business/In							
5	in 72	Completed	(Specify only highest grade completed) (G	ive kind of work done during most of work a. DO NOT use retired)	ring	OD. KING OF BUSINESSAIN	dostry						
212	iene.	шо	Elementary/Secondary (0-12) College (1-4or 5+) Six Years	Homemaker		Personal	Residence						
	othe vent.	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, M	aiden Sumame)							
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other then "naturel", or items 23a or 28a-f show other treumatic event. I're Medical Examinar mast be nutified at	70	Lewis Franklin Reynolds, Jr.	E	va Josepl	nine Bostic							
an		6		ailing Address (Street and Number or Run									
	and lealth m 27 her tr			Independence St.,									
Baltimore,	8 = 5		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	rematory or other place)		0c. Location - City or To							
tim	permit. Pa Departmen Importent: any injury once.		`4 □ Donation 5 □ Other (Specify) Methodi	st Cemetery	.6/05 N	orth East,	Maryland						
Ba	permit. Departr importe any inji		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766										
н	Pnysician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onest and Poath										
		W 1	Immediate Cause (Final disease or condition resulting in death) a										
			Due to (or as a contequence of):	. 1) . 0 .								
		<u>a</u>	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
10		Examiner											
XI	be executed iclan and burial-transit	Exa	that initiated events resulting in death) Last Due to (or as a consequence of):	Concerna 4	TO PY	0							
8760,4	ate be execu hysiclan and he burial-tra		a. Ohlon	ie and an	10,100	lenosa							
9	ig pr	Med	IF FEMALE:				-						
Вох	ath ce Itendi	an/I	23b. Was decedent pregnant 1 Live birth 2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ery Day Year						
0.	The law requires that the ate has been signed by the page 2 should be detache	Physician/Medicai	1 Yes 2 To 4 Pregnant at time of death		nio, iii								
۵.		Ph	Part II. Other significant conditions contributing to death but not resulting in th	underlying cause given in Part I.	23e. Did toba	acco use contribute to the	a to the cause of death?						
Records,		d by			1 Yes 2 No 3 Probably 4 1111								
Sor		Completed		24a. Was an	t. Was an 24b. Were autopsy findings available								
Re		ошо			autopsy perform	ed? prior to co	mpletion of cause of						
Vital		0	25. Was case referred to medical	1 ☐ Yes 2-									
<u>></u>	S D	0 8	examiner? 1 Yes 2 Tho Hospital: 1 Dispatient 2 ER/Outpa			5 Residence 6 Other (Specify)							
Jo u	ding Ph The After th funeral	n: T	27. Manner of Death 1 Natoral 5 Pending (Month, Day Year) Injur	of 28c. Injury at	28d. Describe how injury occurred								
ioi	Hospitel or Attendent to hours after death Funerel Director: tely filled in by the	atic	2 Accident investigation	M 1 Yes 2 No									
Division		Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
		edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month,	Day, Year)						
	٠,		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)	a on da	- 11	7, 2~						
	/		K. NOW, MO, GO). Sould U	mice chine		new Mil)	01018						
(Check only 2 Medical Examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOW, NO 60). South Union State Registrar 31. Date filed (Month, Day, Year) MAY 1 6 2005													

			1 - State of Maryland	-	rtment of H			iene g. No.	05 18145	5
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last) Jacqueline Marie Huffman 1. Decedent's Name (First, Middle, Last)		4b. City, Town, or	I continue of D		7 20	3. Time of Death 3:30 A M	(
	Examin	er	4a. Facility Name (If not institution, give street and number) 645 Knights Island Road		Earlevil			4c. County Cec:	il	
	Funeral Director		5. Social Security Number 6. Sex 1	Yrs.	Months Days		Hrs. 8. Date of Birth (Month, Day, Dec. 29	,1942	9. Birthplace (State or Foreign Country) Georgia	<i>¬</i>
	Maryland I-f show	tor	10a. State 10b. County 10c. City	Town or Local					10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	with the 3a or 286 If be nut	i Direc	10e. Street and Number 645 Knights Island Road		10f. Zip Code 2191	.9		0g. Citizen of V	What Country?	
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If time 27 is marked other then "neturel" or items 23a or 28a-f show any injury or other treumatic event, it a Machical Examinal mast be mailfied at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Norced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No on U.S. Armed Forces? 1 Yes 2 No on U.S. Armed Forces? 1 Yes 2 No on U.S. Armed Forces?	i	Vas Decedent of Hi i Yes, specify Cubar	spanic Origin? n, Mexican, Po Specify:	(Specify Yes or No- uerto Rican, etc.)		ce - American Indian, ck, White, etc.	
N-6171:	within 72 hou ene. then "neture ne M. Alfall	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give i life. [lent's Usual Occupa kind of work done d DO NOT use retired, retary	lurina most of	working	16b. Kind of B	usiness/Industry	
ylanu z	ould be filed Mental Hygi arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Last) Paul Maynard Gess				Name (First, Middle, M Willeen Cl	Maiden Suman		
, Mar	and 2 she saith and n 27 is ma er treum		19a. Informant's Name/Relationship (Type, Print) Kim White/ daughter	2458	2 Smithvi		ad Worton,			
HOLE	Pages 1. nent of He int: If iten iry or oth	4	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	emetery, crem	sition <i>(Name of</i> natory or other place e Cremati	1			- City or Town, State	
Dallimor	permit. Departn Importe any inju		21. Signature of Funeral Service Licensee	> Fe	Name and Addres 11ows, He U Speer K	s of Facility 1fenbe d. Che	in, Newnam stertown,	FUnera	al Home PA 20 778-0055	
	certificate be executed directly special directly special frankit as the burial-Iransit cas the burial-Iransit directly special frankit directly s	ical Examiner	23a. Part 1. Enter the disease, or compliation that caused the death shock, or heart failure. List only the cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of	i. Do not ente		g, such as care			Approximate Interval Between Onset and Death	
<u>.</u>	death certific e attending p ed for use as	Physician/Medic	d	death 3	Ectopic pregnancy Other (specify)				ate of delivery onth Day Year	
J.	faw requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resu	ulting in the ur	nderlying cause give	en in Part I.		oacco use c <i>o</i> nt es 2 □ No	tribute to the cause of death? 3 Probably 4 Monknown	,
ב	The tte h	Completed					24a. Was a autops perform	ned?	Were autopsy findings available prior to completion of cause of death? 1 Yes 2 14 No	,
	Phys rthis ral dii	ation; To Be	27. Manner of Death 1 ☐Matural 5 ☐ Pending (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	er: 4 ☐ Nursin	Death (Check only only only only only only only only	ence 6 □Oth		
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certificat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre		763 2 110	28f. Location (St City or Town		per or Rural Route Number,	
	the Hospi hin 24 hour the Funera	Medical (29a. Certifier (Check only one) 1 Sertifying Physicien: To the best of my know one) 2 Medical Exeminer: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the time vestigation, in my op	oinion, death o	ccurred at the time, d	ate and place,	anner as stated, and due to the cause(s)	
	Vitit To Cor	-	29b. Signature and little of certifier. 30 Name and address of person who completed cause of death (Item	230\ 77.40	up Doc	056	449	5/1	7/05	
**.	Sta		30. Name and address of person who completed cause of death (item Simonson WD WM 31. Date filed (Month, DayMAY 1 8 2005 Registres Signat	est.	Aigh S	4. S.	ute 302	ElKt	n MD 2192	4
	Registi	rar		-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - For State Registrer Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year AM **Physician** May Philip Lawrence Henry /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Washington County Washington County Hospital Hagerstown If Under 1 Year Months Days 7. Age (In yrs. last birthday) Birthplace (State or F Country) -oreigr 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 XM 2 ☐ F 82 Director 217-12-1674 April 9 1923 Virginia Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location with the Maryland 10b. County 10a. State ral, or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 No Maryland Washington Hagerstown Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 125 West Side Ave. 21740 United States filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 \subseteq No 1-10-43 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: White 21215-0036 If Yes, Give Year or Dates: 12-10-45 δ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Door Mfg Crater 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Mental Pages 1 and 2 should be is marked o Philip Henry Florence Henry 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Emma B. Henry 125 West Side Avenue Hagerstown, Maryland 21740 (wife) if item 27 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ò permit. Page Department of Important: if any injury or once. Rose Hill Cemetery May 19, 2005 Hagerstown Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Douglas A. Fiery Funeral Home 1331 Fastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** MULTIORGAN FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transi METNICILLIN RESISTANT STAPHYWCOCCUS AUREUS and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ō in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. detached of Vital Records, P.O. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe page 2 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred funerai 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide in by 4 Homicide filled within 24 hours To the Funeral 1 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only onel and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ē Mobily MD D62562 05-17-05 Machan WASHINGTON COUNTY MOSPITAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADMA・I MUSBLY 5H-2 MARYLAND MAGERSTOWN 21740 STREET E. ANTLETAM 32. Registrar's Signature 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

State

Registrar

18 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2:20 P.M. William Haberbeck, Jr. Mai John 2005 10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington County Hospital Hagerstown Washington 8. Date of Birth (Month, Day, Year) June 5,1943 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours XXM 2 F Months 61 Maryland Director 213-40-7054 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 ahow any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21740 USA 17306 Claymont Drive Funeral 12. Was Decedent Ever in U.S. Amped Forces?
12. Yes 2 No 196
If Yes, Give Year or Dates: 197 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1964 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify. þ 1970 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Assembly Line Worker Truck Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ျှ John William Haberbeck Dorothy Lucille Plantz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17306 Claymont Drive Hagerstown, Maryland Betty J. Haberbeck - Wife 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Spepity) Greenlawn Mem. Park May 20,2005 Williamsport, Maryland 21. Signature of Funeral \$ Osborne Afanersily Home, P.A. any ir 425 S. Conococheague St.Williamsport,MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such its cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Dea Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate name. Enter Indenying Due to (or as a consequence of): Examiner Cause (Disease or injury that initiated events resulting in death) Last burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Dav 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No should be detached 9 Unknown 9 Unknown Par/II) Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2□ No 1 ☐ Yes 2 HNO 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2.☐ No Inpatient 2 ER/Outpatient 3 DOA 2 funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Injury 1 Natural 5 Pending 1 □ Yes 2 □ No To the Hospitel or Attendii within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 estitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar

State

410+1

and address of person who complete

8

(Item 23a) (Type, Print)

MILL

TI MA

32. Refistrar's Signature

			a FOI	R Indelible Ink. Ensure A Department of Health and N Certificate of Death	Mental Hygie	
	Physici /Medi Examir	cal	Decedent's Name (First, Middle, Last) PAULINE ELIZABETH HUGHES 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	2. Date of Death Month MAY	Day Year 16, 2005 3. Time of Death 0220 M
	Funeral Director		17827 BAKERSVILLE ROAD 5. Social Security Number 219-66-2148 Usual Residence of Decedent 1	hday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	WASHINGTON 9. Birthplace (State or Foreign County MARYLAND)
	ith the Maryland or 28a-f show	ector	10a. State 10b. County 10c. City, Town MARYLAND WASHINGTON 10e. Street and Number	BOONSBORO	100	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with 23a or 3	al Dir	17827 BAKERSVILLE ROAD	10f. Zip Code 21713	log	. Citizen of What Country? U-S-A-
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If itsm 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be mutiled at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No It Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (SI If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- c Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
21215-0036	d within 72 ho piene. r than "natur the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of won life. DO NOT use retired) HOMEMAKER	king 16	b. Kind of Business/Industry OWN HOME
Maryland 2	2 should be filled withir and Mental Hygiene. is marked other than aumatic event, the Me	To Be C	17. Father's Name (First, Middle, Last) VICTOR CHARLES POFFENBERGER 19a. Informant's Name/Relationship (Type, Print) 19b.		HALLER	
	and 2 sl salth an n 27 is r		CAROLYN WINFIELD, DAUGHTER	13120 MARTIN ROAD, S		
Baltimore,	Pa ant:		1 □ Burial 2 🖟 Cremation 3 □ Removal from State SMITHS		9/2005	c. Location - City or Town, State SMITHSBURG, MARYLAND
Bal	permit. Departr Importa		21. Signatur of Fundal Service Consee Kelly A. Zimmerman	22. Name and Address of Facility BAST FUNERAL HO		OLD NATIONAL PIKE SORO, MARYLAND 2171
68760,	Physician and bhysician and bhysician and bhysician and the print	dical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the condition of); (*):		Interval Between Onset and Death 2
P.O. Box 6	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 2 Fetal death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in Drabelise melling the Hypertens con	the underlying cause given in Part I.		cco use contribute to the cause of death?
of Vital Records,	rsicien: The law r s certificate has be lirector, page 2 sh	Completed	<u> </u>			24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
Division of Vit	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification; To Be	1 Autural 5 Pending (Month, Day Year) In 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, fair building, etc. (Specify)	tpatient 3 DOA Other: 4 Nursing H Time of Point Nursing H Nursing H Nursing H Nursing H Nursing H Nursing H Nursing H Nursing H Nursing H Nursing H	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
	o the Hosp ithin 24 hou o the Fune ompletely fi	Medicai	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge 2 ☐ Medical Examiner: On the basis of examination and and manner stated. 29b. Signature and tile of certifier	, death occurred at the time, date and place d/or investigation, in my opinion, death occu	rred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s) 1. Date signed (Month, Day, Year)
	⊢≯⊢ŏ			D 44996		
SH-	4		29 ar malik no 203/16	ippans Rd Boons	6020	MB 21713.
	St Regist	ate rar	31. Date filed (Month, Day, Year) MAY 1 7 2005 32. Registrar's Signature	Type, Print) sphans Rd Boons Spele		

DHMH 17 Rev 1/2001

			For Stata Registrar	State of N	/larylar		artment of F tificate of a				giene Reg. No.	05	18149)
	Physici		1. Decedent's Name (First, Middle, La Grace Eugenia HES	•	-					2. Date of Dea Month May 13	Dav	Year	3. Time of Deat	
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and numbe	er)		4b. City, Town, o	r Location		1107_15	4c. C	ounty of Death		
			7910 Pendleton C		Age (In vre	last birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Birt		shingt	on place (State or For	oian.
	Funeral Director		236-28-7462	DM OFF	6	Yrs.	Months Days	Hours	Min.	(Month, Day April	9,190	9 West	Virginia	a
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Lin	nits
	Mary Be-f sh	tor	Maryland Washin	gton		Hag	erstown						1 ∛ Yes 2 ☐	No
	th with the 23a or 28 ast be not	ai Director	10e. Street and Number 355 S. Cannon A	venue			10f. Zip Code 2.	1740			10g. Citize USA	on of What Co	intry?	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 W Widowed 4 Divorced	12. Was Deceder Armed Force: 1 Yes 2 If Yes, Give Year or Dates	s? жNo	1	Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 ☑ No	lispanic Or an, Mexica Specify	n, Puerto F	cify Yes or No- Rican, etc.)		Race - Amer Black, White Specify: Wh	, etc.	
15-0	n 72 hc	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		(Give	lent's Usual Occup	durina mos	st of working	ng .	16b. Kind	of Business/l	ndustry	
121	within lene.	dwc	Elementary/Secondary (0-12)	College (1-40	r 5+)	1	00 NOT use retired memaker	²⁾			he	er own	home	
Maryland 2	should be filed withind Montal Hygiene. marked other than imatic event, I'm	To Be Co	17. Father's Name (First, Middle, Last, James A. Prather							(First, Middle, E. Muc		umame)		
ary	2 shoul and Mi Is mari	-	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (Street	and Numb	er or Rural	Route Numbe	er, City or 1	Town, State, Z	p Code)	
	of Health Item 27		Phyllis Spielman	- daughte			O Pendle	ton C		-t-	00.1		200	
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or otl		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specif		، ا م	cemetery, cren	sition (Name of natory or other plac wn Mem. F		5/16	/05		rstown	own, State Marylan	d
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licer	To large			. Name and Addre		LITIA	NICH FU Hagers			and 2174	0
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caus one cause on each	ed the dear	th. Do not ent	er the mode of dyin	ng, such as	s cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death	1
	/Medical Examiner		disease or condition resulting in death)	a. HSC Due to (or a	as a consec	quence of):								
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	as a consec	quence of):					<u>.</u>			
,	ficate be executed physician and s the burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or a	as a consec	quence of):								
68760,	ite be iysicia ne bur	dicai	(d										
_	artifica ing ph e as th		IF FEMALE:											
.O. Box	it the death certific by the attending p tached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Feta	al death 3	Ectopic pregnancy Other (specify)	'			23	d. Date of delin Month	rery Day Year	
s, P	es tha gned be de	by	Part II. Other significant conditions of	contributing to death	but not res	sulting in the u	nderlying cause giv	en in Part	l.				the cause of death	
Record	w requir been si should	ietec	4 +/	y on wo						24a. Was			opsy findings availa	
l Re	The ate h page	Completed	- 11 points ais							autop perfor 1 Yes		prior to c death? 1 ☐ Yes	mpletion of cause	of
Vital	Physicien: This certificate director, p	Be	25. Was case referred to medical examiner?	Hospital:			Oth	or		(Check only o			Janght	
of		7: To	1 XYes 2 No 27. Manner of Death	1 ∐ Inpa 28a. Date of Ir	njury	28b. Time of	28c, Injur	v at		ne 5 Resid		Other (Spec	Hags stown	
ion	ath. r: Aft	atior	Natural 5 Pending 2 Accident investigation		Day Year)	Injury	M 1 🗆	k? Yes 2□]No					1740
Division	al or Atten s after deat! I Director: d in by the	Certification;	3 Suicide 6 Could not be determined	286. Place of I	njury - At h etc. <i>(Speci</i>		eet, factory, office		2	8f. Location (S City or Tow	Street and i	Number or Ru	al Route Number,	
	To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by th	edical C	29a. Certifier 1 Certifying Ph	nysicien: To the bearing: On the basis and manner	of examina	owledge, death ation and/or in	occurred at the tin vestigation, in my o	ne, date ai pinion, dea	nd place, a ath occurre	nd due to the o	cause(s) ar date and p	nd manner as lace, and due	stated. to the cause(s)	
	To th within To th comp	Me	29b. Signature and title of certifier				29c. Licens	e number			29d. Date	signed (Month	Day, Year)	
,			20 Name of odd			E MO		005	6965		5	116/05		
4	1-4		30. Name and address of person who	1 - 4 -	54	Home		mo	217	40				
	Sta		31. Date filed (Month, Pay, Year)	005 32. P egis	strar's Sign	ature	eles		<u> </u>	_				
	Registr	ar	PINI 1 1 4	UUS Jake	w ,	1. pp	wa							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🛛 🗍 🕤 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Vear **Physician** 9:45 P May 14, 2005 Hergert /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Renaissance Gardens Spring Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 ☐ M 2 🔀 F Yrs. 82 5,1923 Texas Director 463-22-0929 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. County 10c. City, Town or Location 10a. State Show r then "natural", or Items 23a or 28a-f shov the Medical Examinar is ust be notified at 1 ☐ Yes 2 X No Highland MD Howard Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20777 United States 13730 Briaridge Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or item any injury or other treumatic event, the Medical Exambles once. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martha Louisa Hight William Franklin Ballard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13730 Briaridge Court, Highland, MD 20777 Sam Hergert / Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition ochiltree County May 19, 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2005 Perryton, Texas Cemetery 22. Name and Address of Facility
Boxwell Brothers Funeral Home Inc.
310 SE 32nd St., Perryton, TX 79070 21. Signature of Funeral Service decenses Approximate Interval Between Onset and Death 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MONTHS **Physician** METASTATIC MALIGNANT MELANOMA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical as attending IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day for 4 Pregnant at time of death 5 ☐ Other (specify) P.0. the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 27 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? has 1 ☐ Yes 2 ☐ No 2 √ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 2 ER/Outpatient 3 DOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 1 ☐ Yes 2 🔯 No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: al or Attending Patter death. After Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in the property of the cause (s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Day, Year) of certifier 29c. License number 29b. Signature and title May 16, 2005 D24035

State Registrar 31. Date filed (Month, Day, Year) MAY 16 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3110 Gracefield Road, Silver Spring, Eugenio S. Machado, M.D. Registrar's Signature

10

20904

			For State Registrar	State of Maryla	•	artment of Heal			iene og. No. 005	18151
			1. Decedent's Name (First, Middle, Last)				2	2. Date of Deat Month	h Day Year	3. Time of Death
Н	Physici: /Medic		George Luther Hus	ton				05	12 05	14:40 P M
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or Loca	ation of Death	_	4c. County of Dear	th
			Peninsula Legiona	Medical C	enter	Salisbo	114		Wicom	0
	Funeral		5. Social Security Number 6. Sex		s. last birthday)		Under 24 Hrs. ours Min.	B. Date of Birth (Month, Day, August	16,1918 Bir	thplace (State or Foreign ountry)
	Director	-	217-36-0271 Usual Residence of Decedent	M 2LIF 86	Yrs.			August	10,1910 Ma	aryland
	and and		10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Limits
	f ehc	ō	MD Wicomico	Heh	oron					1 ☐ Yes 2 No
	the 28a-	Director	10e. Street and Number	1100	<i>7</i> L 011	10f. Zip Code		1	0g. Citizen of What Co	ountry?
	3a or		27337 Lillian St.			21830			USA	
	me 2:	Funeral		2. Was Decedent Ever in	U.S. 13.	Was Decedent of Hispan	nic Origin? (Spec	ify Yes or No-	14. Race - Ame	
SO.	or ite	Fü	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 □ No		f Yes, specify Cuban, M		ican, etc.)	Black, Whit	
5-0036	hours after death with the Maryland Lural', or Iteme 23a or 28a-f show at Examinar must be mutified at	i by	3	If Yes, Give Year or Dates: Arn	ny	1 ☐ Yes 2 🙀 No Sp	pecify:		Specify: Wi	irce
2-0	72 h netu dicel	Completed	15. Decedent's Educ (Specify only highest grade	eation completed)	16a. Dece	dent's Usual Occupation kind of work done during DO NOT use retired)	n Ig most of working	9	16b. Kind of Business	/Industry
2	nen.	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)						
7	filed within 72 Hygiene. other than "nal ent, the Medic		9 17. Father's Name (First, Middle, Last)		Dairy	7 Farmer	Mother's Name	Eiret Middle A	Agricultui Maiden Sumame)	ce
anc	ould be filed with Mental Hygiene. arked other that atic event, the	Be					eulah M.			
aryland	2 should be filed within 72 hours after death with the Marylar and Mental Hygiene. Is marked other than "natural", or Iteme 23a or 28a-f show armatic event, the Medical Examiner must be notified at amantic event.	2	G. Leroy Huston 19a. Informant's Name/Relationship (Type	na Print)	19h Mailir	ng Address (Street and I				Zin Code)
Ma	permit. Pages 1 and 2 should I Department of Health and Men Important: If Item 27 is marke any injury or other traumatic once.		Joyce Phillips/ Da			Sharptown			*	
ā,	1 and Health tem 27 other tr	1	20a. Method of Disposition		. Place of Dispo	sition (Name of	Da		20c. Location - City or	
פֿ	Pages nent of I int: If Ite		1 Burial 2 □ Cremation 3 □ Re 1 □ Donation 5 □ Other (Specify)	emoval from State	cemetery, crei oring H:	natory or other place)	May	16,2005	5 Hebron	, Maryland
altimore,	permit. Pages Deportment of Important: If I any njury or o	li	21. Signature of Funeral Service Lices		22	Name and Address of	Facility	-		
Ba	permit. Departr Imports any nju	r	16. H R KB	iner (FIB	2	Holloway Fu 501 Snow Hi	neral Ho	me Proi	fessional A	Association
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the de						Approximate Interval Between
	Physician	V) (1	Immediate Cause (Final	Pheum	200 W 121211	20				Onset and Death
	/Medical		disease or condition resulting in death)	Due to or as a cons		2	0			
	Examiner		Convention let conditions	My	to days	morre	m	non	re	3 400
	₽ #	ner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a cons	equence of) 🛭	7	/			,
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
50,	cate be executed chysician and the burial-transit	<u> </u>	Toodhing in dodiny East	Due to (or as a cons	equence on:					
8760,	ficate be executed physician and s the burial-transit	dical	d	l						
9 X	The law requires that the death certificate has been signed by the attending I age 2 should be detached for use as	Physician/Me	IF FEMALE:	3c. If yes, autcome of pred	inancy				23d. Date of de	liven.
Вох	atten for u	clan	in the past 12 months?	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)			Month Month	Day Year
o.	the d y the iched	ysi	1 Yes 2 No 9 Unknown	9□ Unknown						
<u>α</u>	that ned b	by Pt	Part II. Other significant conditions con	tributing to death but not r	esulting in the u	nderlying cause given in	n Part I.	23e. Did toi	bacco use contribute t	o the cause of death?
Records,	w requires that been signed to should be deta	d b						1 🗆 Y	95 2 No 3 P	robably 4 ☐Unknown
00	aw recast been as been 2 short	Set						24a. Was a		utopsy findings available
	The lav	Completed	****					autops perform	med? death?	completion of cause of
Vital		a)	25. Was case referred to medical			26.	i. Place of Death			22.10
	d is	To B	examiner? 1 ☐ Yes 2 No	lospital: Inpatient 2	☐ ER/Outpatier	nt 3 DOA Other:	4 ☐ Nursing Hom	e 5 Reside	ence 6 Other (Spe	ecify)
0		:uc	27. Manner of Death 1 SNatural 5 ☐ Pending	28a. ate of Injury (Month, Day Year)	28b. Time o	f 28c. Injury at Work?	2	8d. Describe h	ow injury occurred	
Sio	Attending or death. ector: After by the fune	catio	2 Accident investigation			M 1 ☐ Yes	2 🗆 No			
Division of	l or Attendated after death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe		reet, factory, office	2	8f. Location (Si City or Town	treet and Number or R n, State)	lural Route Number,
Ω	ospital of hours at number of pilled in the									
	T 4 IT 0	edical	29a. Certifier (Check only one) Certifying Physical Exemination (Check only one)	sicien: To the best of my k ner: On the basis of exami and manner stated.	nowledge, deat ination and/or in	h occurred at the time, over stigation, in my opinion	date and place, a on, death occurre	nd due to the c d at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
	within 2 To the Somplei	Med	29b. Signature and title of-certifier	and mailler stated.		29c. Ligense nu	ımber	2	29d. Date signed (Mon	th, Day, Year)
}	- 3 - B		Magno	mo		1) 2	0507		5/13/05	
	1 min		30. Name and address/ol person who co	impleted cause of death (li	tem 23a) (Tvne	Print)			1	
	IVIT		JOSEPH W.	CR WSSO	111		PRAVI	St S	ALISBV	my m
	Sta	ate	31. Date filed (Month, Day Year) 6 2	00 00 000		hack .				,
	Regist	rar	III/TI I U Z	PHILLIPS	N. 16	Time !				

George Huston 21-36-0271

				Please	State of Ma							3	101120
			for State Registrar			a. y (a. 1.a. / .		ficate of		Memai m	Reg. No	-000	18152
	Physicia	an		e (First, Middle, La	st)					2. Date of D		у Хөас	3. Time of Death
	/Medic	al		I SUSAN H							_0	4 05	19:20 PM
	Examin	er	Sarre	HANY-	e street and number)	Hal	4	CHY, Town, o	r Location of Deal		40	County of Deatl	nu
	uneral		5. Social Security N		Sex 7. Ag	e (In yrs. last bi	N.	Under 1 Year Ionths Days	If Under 24 Hrs		rth ay, Year)	9 Birth	hplace (State or Foreign untry)
	irector		235-80-8 Usual Residence o	3042	2101	55	Yrs.			12-12-	1949	R	IPĹEY
iryland	wow.		10a. State	10b. County	<u> </u>	10c. City, Tow	n or Locat	ion					10d. Inside City Limits
he Ma	28a-1 s	Director	WV 10e. Street and Nu	MINERAL		KEYSER							1 ☐ Yes 2 ☐ No UNKNOWN
with	3a or	I Dir		KER PLAC	F.			10f. Zip Code 26726				itizen of What Co	untry?
death	ms 2	Funeral	11. Marital Status	TILL I LIIO	12. Was Decedent Armed Forces?	Ever in U.S.	13. Wa		lispanic Origin? (S an, Mexican, Puer	Specify Yes or N		14. Race - Amer	rican Indian,
III C I C I C I O O O O O O O O O O O O	in results and welfare hygeries and angeles is a state of several terms 23s or 28s-1 show them 21s marked other than "natural", or itsumatic event, the Medical Examinar must be notified at	þ	1 Never Marr	ried 2[X Married 4 □ Divorced	1 Yes 2 X If Yes, Give Year or Dates:	No		Yes ATTNo	Specify:	to mican, etc.)		Black, White Specify: WI	e, etc. HITE
n 72 h	"natu	Completed		15. Decedent's E- cify only highest gra	ducation ade completed)	16a	(Give kin	t's Usual Occup d of work done NOT use retire	during most of wo	orking	16b. K	(ind of Business/I	Industry
d with	and Mental Hyglene. is marked other than aumatic evant, the Me	dmo:	Elementary/Second 12	ondary (0-12)	College (1-4or 5			ITUTE 7	•		ED	UCATION	
De file	d oths	Bec	17. Father's Name	(First, Middle, Last)					me (First, Middle	, Maider	n Sumame)	
should	narke natic	ဥ		WARD HAR						HAZEL N			
2 0 :	traun			ame/Relationship (and Number or R				ip Code)
s 1 and	item 27 othar tra		20a. Method of Dis	•		20b. Place o	O BOX		MORGANI	Date	2650 20c. L	ocation - City or	Town, State
mit. Pages	ant: if			XCremation 3 ☐ 5 ☐ Other (Specil	Removal from State	SUNSE	T MEM CREMA	ORIAL C	SARDENS	IKNOWN	KI	NGWOOD W	IV
Dall permit.	Department of Heal Important: If item 2 any injury or other once.		21. Signature of Fo	Meral Service Lice	Molety	Bolyon	22. N	ame and Addre		Till and the second			
	3 2 8 W		23a, Part1, Enter t	the disease. Nor	plication that caused	the death Do	MO	RGANTOW	IN WV 265	006	rroet		Approximate
/N Ex	hysician Medical aminer the burial-transit	Ilcal Examiner	disease or condition resulting in death) Sequentially list confidence in any, leading to incause. Enter Unde Cause (Disease or that initiated event resulting in death)	onditions, nmediate erlying injury s	b. Rus o (as	a consequence a consequence a consequence	8.00	ailu	ect w	& mal	ign	and effi	> 2 78avs
The law requires that the death certificate be executed	hed by tha attending physic detached for use as the b	Physiclan/Med	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 9 Unknown	! months? □ No	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death		topic pregnanc ther (specify)	у			23d. Date of deliment	very Day Year
requires that	n signed b	by	Part II. Other signi	ficant conditions	contributing to death b	ut not resulting i	in the unde	rlying cause gru	ren in Part I.		tobacco (12	the cause of death?
The law rec	bean. tor: After this certificate has been signed the funeral director, page 2 should be de	Completed									psy ormed?	prior to c death?	topsy findings available completion of cause of
in	ctor, p	BeC	25. Was case reference examiner?	rred to medical			· · · · · -		26. Place of De	1 ☐ Yes ath (Check only	2 2 No one)	1 10105	2 No
hysic	this ce	은	1 ☐ Yes 2 ☑	_	and the second second	ent 2 ER/O	-	3□ DOA Ott	4 Nursing i	Home 5 ☐ Res	idence	6 ☐Other (Spec	ufy)
To the Hospital or Attending Physician:	or: After he funer	Certification:	27. Manner of Dear	5 Pending investigatio			Time of Injury	28c. Injui Wor M 1 □	yat rk? Yes 2 □ No	28d. Describe	how inju	ry occurred	
al or Att	s after dead	Certific	3 Suicide 4 Homicide	6 Could not be determined		ury - At home, fa c. (Specify)	arm, street,	factory, office		28f. Location City or To	(Street ar wn, State	nd Number or Ru e)	ral Route Number,
s Hospi	To the Funeral	edical	29a. Certifier (Check only one)	1 ☑ Certifying Pt 2 ☐ Medical Exam	nysician: To the best niner: On the basis o and manner st	f examination ar	e, death oc nd/or inves	curred at the til tigation, in my c	me, date and place opinion, death occ	e, and due to the urred at the time.	cause(s , date and	and manner as d place, and due	stated. to the cause(s)
To th	To th comp	Me	29b. Signature and	title of certifier	\cap			29c. Licens	se number		29d. Da	ite signed (Month	ı, Day, Year)
			30. Name and addition	tess of person was	Kaulla causa of c	leath (Item 23a)	(Type Prin	D -	175	26	Ma-	7 5 36	12005
		-	DR. Joh	in Meh	anna 9	00 SeT	1 40	rive (cumbe	Haud,	M	2 2150	2
	Sta Registr		31. Date filed (Mor	ΔΥ 3 1 200	2. Registr	ar's Signature	dene all						

NAME: ITNYRE, LILY MARK Baltimore, Maryland 21215-0036

		30.0		artment rtificate				Re	g. No.	15	18153
Physici /Medio Examir	al.	Decedent's Name (First, Middle, Last) LILY MARY ITNYRE 4a. Facility Name (If not institution, give street and number)		4b. City,	Town, or	Location of		2. Date of Death Month MAY	14,	2005 unty of Dea	8:00 PM
Funeral		REEDERS MEMORIAL HOME 5. Social Security Number 6. Sex Y 7. Age (In yrs. last bin	thday)	If Under	1 Year	BOONS	4 Hrs.	8. Date of Birth	Vans	9 Ri	ASHINGTON rthplace (State or Foreig
Director		Usual Residence of Decedent	Yrs.	Months	Days	Hours	Min.	JAN. 1,	′1908	WES	ST VIRGINIA
he Maryla 28 a-f s hov	ector	MARYLAND WASHINGTON	n or Lo		-	OONSB	ORO				10d. Inside City Limit
Mith t	i Dir	10e. Street and Number 141 S. MAIN STREET		10f. Zip	Code	2171	3	10	0g. Citizen		ountry? J.S.A.
be filed within 72 hours after death with the Maryland tal Hygjene. do other than "naturel", or items 23a or 28a-f show event, it a Medical Even it or mast be multipad at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	i	Was Deced If Yes, spec		spanic Origi n, Mexican, Specify:	in? (Spec Puerto F	cify Yes or No- lican, etc.)		Race - Am Black, Whi	erican Indian, ite, etc.
ad within 72 hours af giene. ar than "naturel", or t. the Medical Extern	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	DO NOT us	k done d	uring most o	of workin	g	TOY		s/Industry JFACTURER
should ba filed and Mental Hygis s marked othar	To Be C	17. Father's Name (First, Middle, Last) UNKNOWN						(First, Middle, M LEONA O		,	
nd 27 i		19a. Informant's Name/Relationship (Type, Print) GENEVIEVE M. BELL, DAUGHTER	. Mailir 690	ng Address 6 MA R	(Street a	nd Number FURNA	or Rural	Route Number, OAD, BO	City or To ONSBO	wn, State, RO , N	Zip Code) MARYLAND 21
permit. Pages 1 and 2 should be Department of Health and Menick Importent: If item 27 is marked any injury or other treumatic e once.		20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Sign your of Junera Service Scene	ry, crei BOR	natory or ot	her place ETER	Y 5.	Da /1 7 /	2005	BOON	SBORO	r Town, State O, MARYLAND JAL PIKE
Physician /Medical Examiner	ner	23a. Part1. Enleg the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)	16 of):	er the mode	of dying	g, such as c	ardiac or	BOCNSI respiratory arre		PIAIC	Approximate Interval Between Onset and Death
Tha law requires that the death certificate be executed to has been signed by the attending physician and rage 2 should be detached for use as the burial-transit	cian/Medicai Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3[Ectopic pre					23d.	Date of de	olivery Day Year
res that the de signed by the a I be detached i	Physici	9 Unknown 9 Unknown	- th			n in Oart I		230 Did tob	2000 1100 0	ontributo t	o the cause of death?
or Attending Physicien: Tha law requires the death. Director: After this certificate has been signed in by the funeral director, page 2 should be come.	ted by	Athrosclerosis	1 110 01	ndonying oc				1 □ Ye	1.		robably 4 Unknown
	e Completed	Athrosclevsis Hyfilstensim Alzheimer's Dise	eas	<u>.</u>					ed? No	b. Were a prior to death?	
ing Ph h. After th funeral	ertification; To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou 27. Manner of Death Shatural 5 Pending investigation investigation 2 Accident investigation	sing Hom	ath (Check only one) dome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred							
To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	O	4 Homicide determined 256. Place of mighty Arribme, la building, etc. (Specify) 29a. Certifier The Certifying Physicien: To the best of my knowledge		n occurred a	at the tim	e, date and	place ar	City or Town,	State)	manner a	ural Route Number,
the Ho hin 24 h the Ful npletely	Medical	one) 2 Medicel Exeminer: On the basis of examination and manner stated.	d/or in	vestigation,	in my op	inion, death	occurre	d at the time, da	te and plac	e, and du	e to the cause(s)
With To		29b. Signature and Ne of certifier			License D41	199	6				LOUS
Sta Registr		DR. ZAFAR MALIK 20311 LAPPANS RC 31. Date filed (Month, Pay Year) 32. Refistrar's Signature			ISB0I	RO, ME) 2	21713			

JET 05-03466

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 2 per me 2043 5-31-05 vt

May 19 · 2005

ro	tny M.		INSON For State Registrar	State of M			of Health and of Death		ene () () 5	18154
			Decedent's Name (First, Middle, Last)					2. Date of Peath	1	3. Time of Death
	Physici	an	DOROTHY MAXIN	E JOHN	SON			May 18	Duy 10	2:00 A ^M
4	/Medic		4a. Facility Name (If not institution, give s			4b. City, To	wn, or Location of Dea		4c. County of D	
	Examin	er				Cumbe	rland		Allegan	ıv
	Euroval		235 Paca Street 5. Social Security Number 6. Sex	7. Ag	je (In yrs. last birthda	y) If Under 1	Year If Under 24 Hrs	8. Date of Birth	9.	Birthplace (State or Foreigr Country)
	Funeral Director		219-03-8540	M 2 X □F	90 Yrs.	Months E	Days Hours Min	APR 11		MARYLAND
			Usual Residence of Decedent							
	yland		10a. State 10b. County		10c. City, Town or					10d. Inside City Limits 1X☐ Yes 2☐ No
	Mar 3-1 st	ţ	MD ALLEGA	NY.	CUMBER	RLAND				N tes 2 No
	r 28	Director	10e. Street and Number			10f. Zip C		10	Og. Citizen of What	Country?
	eth with the Marylan 23a or 28e-f show ust be natified at	ai D	235 PACA STREE	\mathbf{T}		215	502		U.S.A.	
	hours after deeth with the Maryland turel', or items 23a or 28e-1 show at Examirish out be notified at	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 1	3. Was Deceder	nt of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - A Black, V	merican Indian, Vhite, etc.
9	after dee or items	Ē	1 Never Married 2 Married	1 Yes X		1 ☐ Yes 25			Specific	
8	hours a	by	X □ Widowed 4 □ Divorced	Year or Dates:			A		оргону.	WHITE
21215-0036	hin 72 hours after dee 9. an "neturel", or items Madical Examinatio	ted	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. De	cedent's Usual (ve kind of work	Occupation done during most of wo retired)	orking	16b. Kind of Busine	ess/Industry
21	within 7 ene. than "r	pje	Elementary/Secondary (0-12)	College (1-4or	5+)				HOME	
2	- '- b -	Completed	UNKNOWN		H0	OMEMAK!			HOME	
p	be filed tal Hygi d other	Be (17. Father's Name (First, Middle, Last)	, CD				ame <i>(First, Middl</i> e, <i>N</i> ETTA KA		SHAFFER
<u>a</u>		10	CHARLES SEITZ	SR.						
Maryland	d 2 should th and Mer 7 is marke treumetic		19a. Informant's Name/Relationship (T)	pe, Print)			Street and Number or F			ne, Zip Code) 32792
	1 and 2 Health tem 27 i		GENE KERR / SC	N			NTO CIRCLE			
Baltimore,	8 = 0		20a. Method of Disposition 1 ☐ Burial 2 ②Cremation 3 ☐ F	iomoval from State	20b. Place of Dis	sposition (Name rematory or oth	of er place)	Date 2	20c. Location - City	or Town, State
Ē			1 ☐ Burial 2 ② Cremation 3 ☐ F	temoval nom State	CUMBERLA	ND CREM	ATORY 05/	24/2005	CUMBE	RLAND, MD
=======================================	- F # - F		21. Signature of Funeral Service Licens	9		22. Name and	Address of Facility CH FUNERAL	HOME. P.	Α.	
ä	Depar Impo eny ir	10 0	Mondy 8), 5	10chsus	050	202 GR	EENE STREE	T, CUMBER	LAND, MD	21502
			23a. Part1. Enter the disease, or complished, or heart failure. List only of	cations that cause	d the death. Do not	enter the mode	of dying, such as cardi	ac or respiratory arre	est,	Approximate Interval Between
			Immediate Cause (Final	4 10 L	ieva Ar	barrel	enotic Con	disse of	- Vice	
	Physician /Medical		disease or condition resulting in death)	a. The to (or a)	s a consequence of):	72004	-1000	- Consider	. 000	
	Examiner			10 (0. 4.	, a coco que					
1		P.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	s a consequence of):					1
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
_	cate be executed physician and the burial-transit	xar	that initiated events resulting in death) Last	Due to (or a:	s a consequence of):					
68760,	be e ician buria	aiE	l.							
87	icate phys s the	dicai	•	d						4
			IF FEMALE:	23c. If yes, outcom	e of pregnancy				23d. Date of	delivery
Вох	death certif e attending ed for use as	ian	230. was decedent pregnant	1 Live birth	2 Fetal death	3 Ectopic pred			Month	Day Year
	0 0 2	Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	9 Unknown	at time or death	J Other (spec				
P.0	faw requires that the de as been signed by the a 2 should be detached f	Ph	Part II. Other significent conditions co	ntributing to death	but not resulting in th	e underlying cau	use given in Part I.	23e. Did tob	pacco use contribu	te to the cause of death?
Ś	res tha signed be det	by	Dubates A	eliti.		, ,	J	1 □ Ye	s 200 No 3	Probably 4 □Unknown
Record	w require been si should l	Completed	10000131.	No los						r range
e C	as b	pie						24a. Was a autops perform	n 24b. Wer sy prior ned? deal	e autopsy findings available r to completion of cause of
H	The ete h page	No						Yes 2	2 □ No 19	Yes 2□ No
Vital	rtifical	Be (25. Was case referred to medical examiner?				26. Place of D	eath (Check only on	e)	
£ \	ding Physician: The tav h. Afer this certificete has funeral director, page 2	10	1 Yes 2 No	Hospital: 1 🗌 Inpai	tient 2 ER/Outpa	itient 3 DOA	Other: 4 Nursing	Home 5 Reside		Specify)
J Of	ig Pt ter th		27. Manner of Death 1	28a. Date of In (Month, D	jury 28b. Tim lay Year) Inju		c. Injury at Work?	28d. Describe ho	ow injury occurred	
0	Attending r death. ector: After oy the fune	atic	2 ☐ Accident investigation			М	1 Yes 2 No			
Division	Atte	iffi	3 Suicide 6 Could not be determined		njury - At home, farm etc. (Specify)	, street, factory,	office	28f. Location (St City or Town		or Rural Route Number,
O	s efter self self in the self	Certification:								
	ospil hour mere ly fille		29a. Certifier 1 Certifying Physical Exam	rsician: To the bes	of examination and/o	eath occurred a	t the time, date and pla in my opinion, death oc	ce, and due to the courred at the time d	ause(s) and manne	er as stated. due to the cause(s)
	To the Hospitel or Attendir within 24 hours efter death. To the Funerel Director: Af	Medical	one) 21 Medical Exam	and manner	stated.					
	To the complete	Σ	29b. Signature and title of certifier			29c.	License number	2	9d. Date signed (A	nonin, Day, rear)

State Registrar

31. Date filed (Month, Day, Year)
MAY 3 1 2005

111 Penn Street Baltimore Maryland 21201

			For State Registrar	State of Ma	-	artment o		and Mental H	ygiene ()	05 18155
	Physici		Decedent's Name (First, Middle, L Emma Jer	•	_			2. Date of D Month Man	Day 7,2005	3. Time of Death 1:19am M
	/Medic Examin		4a. Facility Name (If not institution, gr	ve street and number)		4b. City, Tow	m, or Location of			y of Death
	LAAIIIII	C1	Charles County		ne	Lap1	ata		Char	les
	Funeral				e (In yrs. last birthda)	-	ear If Under	24 Hrs. 8. Date of B	irth Day, Year) 1 6,1926	Birthplace (State or Foreign Country)
	Director		459-32-1886 Usual Residence of Decedent	1 □ M 2 □ NF	79 Yrs.	Months	iys Hours	March	6,1926	Longview,TX
	land ow		10a. State 10b. County		10c. City, Town or i	ocation				10d. Inside City Limits
	Mary First	tor	MD Charle	S	Laplata	l.				1 X Yes 2 □ No
	th the or 28,	Jirec	10e. Street and Number			10f. Zip Cod	de		10g. Citizen of	What Country?
	23a 23a	ral	10200 Laplata R	d			646			ed States
	ar deg	nne	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 13	. Was Decedent If Yes, specify (of Hispanic Orig Cuban, Mexican	gin? (Specify Yes or N , Puerto Rican, etc.)	lo- 14. Ra Bla	ce - American Indian, ack, White, etc.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28e-1 show any injury or other traumatic event, the Mydical Evardinar nast be ruillied at once.	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 N If Yes, Give Year or Dates:	10	1 ☐ Yes 2 💢	No Specify:		Speci	ty: Black
21215-0036	2 hou	ted	15. Decedent's E	Education	16a. Dec	edent's Usual Oc	cupation		16b. Kind of B	Business/Industry
215	hin 7.	ple	(Specify only highest girls) Elementary/Secondary (0-12)	rade completed) College (1-4or 5	(Giv	e kind of work do DO NOT use re	one during most atired)	t of working		
7	ed wil	Соп	10			Homemak			Domes	
Maryland	be fill stal H od ott	Be	17. Father's Name (First, Middle, Las					r's Name (First, Middl	e, Maiden Sumai	me)
3	hould d Mer narke natic	ပ	Napolean Choyc		10h Mai	ling Address (Ctr		Unk or or Rural Route Num	has City as Tour	State Tie Code)
<u>≅</u>	id 2 s ith an 27 is r traur		Angela Jerry/G							
	is 1 and 2. If Health a litem 27 is other trau		20a. Method of Disposition		20b. Place of Disp	osition (Name of	f	. S.E. Was		- City or Town, State
ê E	Pages ent of nt: If I		1 Burial 2 Cremation 3 `4 Donation 5 Other (Spec			ematory`or other. Hill Cei		5-14-05	Suitla	and MD
Baltimore,	mit. partm porta y inju	1	2 Signature of Funeral Service Kice			22. Name and Ad			ral Home	
0	permi Depa Impo any ir once.	-	Xalour	nx	(wo			S.E. Washi		
П			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	mplications that caused y one cause on each lir	the death. Do not e	nter the mode of	dying, such as	cardiac or respiratory	arrest,	Approximate Interval Between
B	Pnysician		Immediate Cause (Final disease or condition	_a_ Renal	Neoplasm					Onset and Death 3 Months
8	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					
		70	Sequentially list conditions,	b. Date to for as	s consecuence of:					
	uted d ansit	min	Sequentially list conditions, it any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events		, , , ,					
oʻ	exectan and rial-tra	Exa	resulting in death) Last	Due to (or as	a consequence of):					
8760,	death certificate be executed e attending physician and od for use as the burial-transit	Physician/Medical Examiner		d						
9	leath certifica attending ph d for use as th	Med	IF FEMALE:							
Вох	ath ce	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetal death 3	□Ectopic pregna			1	ate of delivery onth Day Year
	that the death cer ed by the attendin detached for use	ysic	1 ☐ Yes 2 🛣No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time or death 5	Other (specify	//			
P.O	The law requires that the steep second to the second point the second be detached by the second seco		Part II. Other significant conditions		-	underlying cause	given in Part I.	23e. Did	tobacco use con	tribute to the cause of death?
rds	w requires that been signed k should be det	ed by	Demetia, Cacher	xia,Schizo	phrenia			1	Yes 2□No	3 Probably XXUnknown
000	aw reas bee	Completed						24a. Wa	s an 24b.	Were autopsy findings available
Ĕ		Com						per 1 \(\text{Yes}	formed?	prior to completion of cause of death? 1 Yes 2 No
ita/	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?				26. Place	of Death (Check only		
<u>}</u>	Physician: rthis certifica ral director, I	၉	1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatie		HIL 3 DOA		rsing Home 5 Res		
nc	Jing T. After fune	tion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	Year) 28b. Time Injury	1	njury at Work? 1 □ Yes 2 □ N		how injury occur	rred
Division of Vital Records,	or Attanding after death. Director: After in by the fune	fical	2 Accident investigation 3 Suicide 6 Could not determine	be go Place of Inju	ury - At home, farm, s				(Street and Numi	ber or Rural Route Number,
<u>S</u>		Certification:	4 Homicide	building, etc	c. (Specify)	,,,			own, State)	
	To the Hospital or At within 24 hours after d To the Funerel Direct completely filled in by	edicai C	29a. Certifier (Check only one) 1X Certifying P	hysician: To the best of miner: On the basis of and manner sta	examination and/or i	ith occurred at the nvestigation, in m	e time, date and ny opinion, deat	d place, and due to the	e cause(s) and many date and place,	anner as stated. and due to the cause(s)
	To the H within 24 To the Fi complete	Me	29b. Signature and title of certifier	,	4. 0	29c. Lic	ense number		29d. Date signe	ed (Month, Day, Year)
	80		17,1duss	ein	MO	D5	55455		May 13	,2005
-	(4)		30. Nam and addes of person who Fatima Y. Huss	completed cause of deein M.D. 5			<i>#</i> 101,0	Camp Spring	gs,MD 20	746
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 7 20	3 Registra	ar's Signature					

			1 - For State of M		artment of Health and I	Mental Hygie	2003 10130
	Physici		Decedent's Name (First, Middle, Last) Gary James			2. Date of Death Month May 1	Day Year 3. Time of Death 11:40 am
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Montgomery V		4c. County of Death Montgomery
	Funeral Director		5. Social Security Number 2.18 − 56 − 6.908	ge (In yrs. last birthday) 5 4 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Mar. 20	9. Birthplace (State or Foreign Country) 1,1951 Laurel.Md
	ehow ed at	ō	Usual Residence of Decedent	10c. City, Town or Lo	ocation omery Villiage		10d. Inside City Limits
	with the M a or 28a-1	Direct	10e. Street and Number 9436 Horizon Run Rd		10f. Zip Code 20886	10g	Citizen of What Country? United States
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23s or 28s-f ehow other traumatic event, the Madical Examinating to Delined at	by Funeral Director	11. Marital Status 1 Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Ves 2 Filyes, Give Year or Dates:	No	Was Decedent of Hispanic Origin? (S, If Yes, specify Cuban, Mexican, Puert 1 □ Yes 2 ☑ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	d within 72 hor giene. or than "natura the Medical E	Be Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	(Give life. Su	dent's Usual Occupation kind of work done during most of wor DO NOT use retired) TVEYOT	king 16i	Engineering
Maryland	ould be filed wental Hygis Mental Hygis arked other i	To Be C	17. Father's Name (First, Middle, Last) Earl Hunter James Jr			ne (First, Middle, Mai hy Helen	
	1 and 2 should be Health and Mental tem 27 is marked other traumatic ev		19a. Informant's Name/Relationship (Type, Print) Cheryl J. Thompson si:		ng Address (Street and Number or Ru Cypress Grove		City or Town, State, Zip Code) Wilmington, NC
Baltimore,	Pages 1 and of He ant: If item		20a. Method of Disposition 1 ☐ Burial 2 ② Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)	8 "			c. Location - City or Town, State Princeton, WV
Balt	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service Licensee	22	Name and Address of Facility Cravens-Shires Route 3, Box 20	Funeral Bluefic	Home, INC eld, WV 24701
	Physician		23a. Part1. Enter the bisease, or complications that cause shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition	line.	ter the mode of dying, such as cardiac		, Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as	s a consequence of):			
	cate be executed physician and the burial-transit	Examiner	Lary Leading to Innectate cause. Enter Underlying Cause (Disease or injury that initiated events	s a consequence of s s a consequence of):			
68760,	icate be e physician s the buria	dicai E	d.				
O. Box (that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
rds, P.	w requires that the been signed by the should be detache	þ	Part II. Other significant conditions contributing to death	but not resulting in the u	inderlying cause given in Part I.		cco use contribute to the cause of death?
Vital Records,	The la ate has page 2	Completed				24a. Was an autopsy performer	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
r Vit	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 X Yes 2 No Hospital: 1 Inpat	tient 2 ER/Outpatier	Chan	th (Check only one) ome 5 \(\) esidence	ce 6 ☐Other (Specify)
Division of	ding h. After fune	Certification: T	27. Manner of Death 1 Natural 5 Pending (Month, Digital Control of Injury 1) Pending (Month, Digital Control of Inju	jury 28b. Time of lnjury		28d. Describe how	
Divis	fter c	Certific	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Ir building, 6	njury - At home, farm, str etc. <i>(Specify)</i>	reet, factory, office	28f. Location (Stree City or Town, S	at and Number or Rural Route Number, State)
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	ledicai	29a. Certifier (Check only one) Certifying Physician: To the bes 2 Medical Exeminer: On the basis and manner s	of examination and/or in	vestigation, in my opinion, death occu	rred at the time, date	and place, and due to the cause(s)
)		Σ	29b. Signature and title of certifier	(OME)	29c. License number		Date signed (Month, Day, Year)
	2		30. Name and address of person who completed cause of	death (Item 23a) (Type,	ine Pike, Roccult	to, who los	382
	Sta Registi		31. Date filed (Month, Day, Year) MAY 1 6 2005	trar's Signature	de		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 08, 2005 Physician Annie Mae Kellv 8:40 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Prince George Hospital Center Cheverly If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 05/02/1926 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M X□F 79 Director 579-42-4182 Tennessee Usual Residence of Decedent 10c. City. Town or Location 10a State 10h Counts 10d. Inside City Limits 7 is marked other than "naturel", or Items 23a or 28a-f show traumatic event, the Medical Exercit at mastice notified at 1∏Yes 2∏No Director PG Kettering 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11509 West Branch Drive 20772 U.S.A. Completed by Funeral iled within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11th Patient Examiner Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill iment of Health and Mental H tant: If item 27 Is marked other Be Willie Kimbrough Fannie Stephens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Boulware - Daughter 11509 West Branch Drive; Kettering, MD 20772 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages
Department of
Important: If it
any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Mem. Park 05/14/2005 ' 4 ☐ Donation 5 ☐ Other (Specify) Landover, Maryland 21. Signature of Funeral Service Licensee _22. Name and Address of Facility Freeman Funeral Services P.O. Box 416; Suitland, Maryland 20752 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or shock, or eart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. SUBDURAL Immediate Cause (Final HEMATOMA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequency of Examiner The law requires that the death certificate be executed use as the burial-transi attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐ Pregnant at time of death 5 Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by page 2 should be HYPERTENSION LIVER CANCER 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown KIDNEY CANCER 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan DIABETES MELLITUS certificate 2 No Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ✓ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 3',00 1 ☐ Natural 2 ☑ Accident 5 Pending home 1 ☐ Yes 2 ☐ No investigation after death Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Ryral Royte Number, City or Town, State) 4 Homicide home you MANGER within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 030318 5-13-05

State Registrar

Baltimore, Maryland 21215-0036

P.O.

Division of Vital Records,

31. Date filed (Month, Day, Year) MAY 1 7 2005

JAMES



and of dress of person who completed cause of death (Item 23a) (Type, Print)

SOCI HOSPITAL

CHEVERLY MD 20785

		T = For Stata Registrar	State of Maryla	nd / Depa		lealth and l	Mental Hyg	piene 05	18158
Physic /Med	ical	Decedent's Name (First, Middle, Last) MADAN 4a. Facility Name (If not institution, give s		APUR	4h City Town o	or Location of Deat		th Day Year 12, 2005 4c. County of Death	3. Time of Death 2:00 A M
Funeral Director		10101 DEEP SKI 5. Social Security Number 6. Sex 220-88-8952	T. Age (In yrs	s. last birthday)		AUREL	8. Date of Birth	HOWAR	
th the Maryland or 28a-f show e notified at	Director	Usual Residence of Decedent 10a. State 10b. County MD • HOWARD 10e. Street and Number	10c. C	Sity, Town or Lo	LAUREI 10f. Zip Code		1	log. Citizen of What Co	10d. Inside City Limits 1 Yes X No
laryland 21215-UU36 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic avent, the Medical Evantinar must be redified at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced 15. Decedent's Educ	2. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	16a, Dece	Was Decedent of Hif Yes, specify Cub 1 ☐ Yes 2 ▼ No	pation		U.S.A 14. Race - Ameri Black, White Specify: AS 16b. Kind of Business/I	ican Indian, , etc. IAN INDIAN
g da la ga	Be Completed	(Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+) 5+	(Give	kind of work done DO NOT use retire ENGINEER	18. Mother's Nar	ne (First, Middle, i	Maiden Sumame)	EERING
e, INIALYIANG 1 and 2 should be file Health and Mental Hy, em 27 is marked othe ther traumatic avent,	To	JHANDA MA 19a. Informant's Name/Relationship (Type BHUPENDRA KAPUR/ 20a. Method of Disposition	SON	1010		and Number or Ru	, LAUREL	DEVI T, City or Town, State, Z MD. 20723 20c. Location - City or 7	
baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any njury or other traumatic ones.	L	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses	emoval from State	CHAMBERS	CREMATO Name and Addre	RY 5-1	2-2005	RIVERDALE EMATORIUM,PDALE, MD. 2	, MD.
Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the de- e cause on each line. HYPERTENSIV	th. Do not ent	er the mode of dying	ng, such as cardiad	or respiratory arr		Approximate Interval Between Onset and Death YRS •
te be executed ysician and be build-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a conse	HEROSCI equence of):	LEROSIS				YRS.
the death certificaty the attending phe tached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of delin Month	very Day Year
s the	by	Part II. Dther significant conditions con	tributing to death but not re	esulting in the u	nderlying cause giv	en in Part I.	23e. Did tol	bacco use contribute to	the cause of death? bably 4 □Unknown
	Be Completed	25. Was case referred to medical				26. Place of Dea	24a. Was a autops perform 1 Yes :	rior to c death? 2 X No 1 ☐ Yes	opsy findings available ompletion of cause of
ding Phys h. After this	2	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2[28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Injui	y at		ence 6 □Other (Spec ow injury occurred	(fy)
	Il Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	cify)			City or Town		
To the Hospital o within 24 hours at To the Funeral Di completely filled in	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier	ilcian: To the best of my kiler: On the basis of examirand manner stated.		29c. Licens		_ 2	ause(s) and manner as ate and place, and due 9d. Date signed (Month	Day, Year)
2 St Regis	ate	30. Name and address of person who co RAKESH ARORA 31. Date filed (Month Pay Year) A 1 3 20	, M.D.	14300 (GALLANT F	OX LA.,S	UITE 222	, BOWIE, MD	. 20715

			1 - For Registrar	State of Ma	rylan	d / Depa <i>Cei</i>	artment of	f Health of Deat	n and M th		giene	05	18159
			Decedent's Name (First, Middle, Last	st)						2. Date of Dea	ath		3. Time of Death
	Physici /Medic		ESTHER	LEE	KAPL	AN				Month	S S	2 205	710 PM
	Examin		4a. Facility Name (If not institution, give				4b. City, Town	n, or Location	on of Death		4c. Cou	nty of Death	
			HEBREW HOME OF GR					VILLE				TGOMER	
	Funeral		5. Social Security Number 6. S	ex 7. Age □M 2 💢 F		ast birthday) Yrs.	If Under 1 Ye Months Da		der 24 Hrs. rs Min.	8. Date of Birt (Month, Da	h y, Ye <i>ar)</i>	9. Birth	place (State or Foreign ntry)
П	Director		062-05-1326 Usual Residence of Decedent		88	113.				AUG. 2	6, 191	6 POI	AND
	/land		10a. State 10b. County		10c. City	y. Town or Lo	cation						10d. Inside City Limits
	Man a-f sh	tor	MARYLAND MONTGO	MERY		ROCKVI	LLF						1 XYes 2 No
	th the	Jirec	10e. Street and Number			MOOK 1	10f. Zip Cod	е			10g. Citizen	of What Cou	ntry?
	th will	raic	6121 MONTROSE	ROAD			208	52		ΨI	NITED	STATES	OF AMERICA
	r dea	nue	11. Marital Status	12. Was Decedent E Armed Forces?		S. 13. \	Was Decedent of Yes, specify C	of Hispanic Juban, Mexi	Origin? (Spe ican, Puerto	ecify Yes or No- Rican, etc.)		Race - Ameri Black, White,	
36	s afte	y F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	D	!	1□Yes 2√∏	No Spec	city:		Spe	cify: WHI	тЕ
21215-0036	filed within 72 hours after death with the Maryland thygiene. uther than "naturel", or Items 23e or 28e-1 show ont, the Medical Examiner must be notified at	edt	15. Decedent's Ed		-	16a. Dece	ient's Usual Oc	cupation				f Business/In	
15	nn 72 n "ne Vedis	piet	(Specify only highest gra			(Give	kind of work do OO NOT use re	ne during n	nost of worki	ng			,
212	d with	mo:	Elementary/Secondary (0-12)	4	7	BUSI	NESS OW	NER			BO	OKSTOR	E.
b	e file al Hy I othe	3e C	17. Father's Name (First, Middle, Last)					18. Mo	other's Name	(First, Middle,			
yla	Ments Ments Brkec	To	ISADORE LUBIN						YETI	A VILNA	A		
Maryland	2 sho		19a, Informant's Name/Relationship (1				-			l Route Numbe			
e)	l and tealth om 27		TERRY LUBIN - N	EPHEW	20h P		DEWEY sition (Name of	140		RLAWN,		ERSEY on - City or To	
ŏ	T it of the control o		20a. Method of Disposition 1 Burial 2 Cremation 3		C	emetery, cren	natory or other	place)					
altimore,	it. Pa ntmer rrtant njury		* 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	500	CE		RK CEME . Name and Ad			5/05	PARA	MUS, N	EW JERSEY
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.			'		Į Ď.	ANZANSK	X GOL	ĎŔĘŖĢ _Ŀ	MEMORIA ROCK	ЪЪ, СНА	PEL, 2H	NC2
			23a. Parti. Enter the disease, or com	olications that caused	the death							TID 20	Approximate
**************************************	Physician		shock, or heart failure. List only Immediate Cause (Final			Lord				Ja	-1:51	3 (-	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a			<u> </u>	araso	(Je 10) CC	100	en sa	136	
	Examiner		Constitution for the state of t	b									
-59	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequ	uence of).							
	acuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
8760,	cate be executed physicien and the burial-transit	Ē	resulting in death) cast	Due to (or as a	consequ	lence of):							
87		dicai		d									
9 X	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome of	of pregna	ncv					234	Date of deliv	an/
Вох	eath atter	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetal	death 3	Ectopic pregnal Other (specify				1	Month	Day Year
O.	that the de led by the a detached f	iysį	1 Yes 2 No 9 Unknown	9□ Unknown									
ري ص	es that igned t	by PI	Part II. Other significant conditions of	ontributing to death bu	t not resu	ulting in the u	nderlying cause	given in Pa	art I.	23e. Did to	obacco use c	ontribute to t	he cause of death?
rd	v require been sig should b									101	∕es 2□No	3 ☐ Prof	bably 4 Unknown
Vital Records,	2 2 3	Completed								24a. Was autop			opsy findings available ompletion of cause of
Ä	9 4 9	No.								perfo	rmed? 2 No	death?	2√ No
ita	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?							(Check only o			
of V	d is	2	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatier		ER/Outpatien				ne 5 ☐ Resid			fy)
υú	ding P	ion:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury	1	Nork?	_	28d. Describe t	now injury occ	curred	5
isio	Attending r death.	lcat	2 Accident investigation 3 Suicide 6 Could not be		ny - At ho	mo form str		I □ Yes 2		28f Location /9	Street and Nu	mher or Dun	al Route Number.
Division	l or Attend after death Director;	Certification:	4 Homicide determined	28e. Place of Inju building, etc.			eet, lactory, offi	Ce	'	City or Tox		moer or Hurr	ar nodie rvanoer,
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral		29a. Certifier -1 Certifying Ph	ysician: To the best o	f my kno	wledge, death	occurred at the	e time, date	and place, a	and due to the	cause(s) and	manner as s	stated.
	ne Ho 124 h ne Fui sletely	edicai	(Check only 2 Medical Examone)	niner: On the basis of and manner stat	examinat	tion and/or inv	vestigation, in m	ny opinion, o	death occurre	ed at the time,	date and plac	e, and due t	o the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1.			29c. Lic	ense numb	өг		29d. Date sig	ned (Month,	Day, Year)
	7/		Consul	Ming	7-25		P:	4490	0フ		Man	9.	2005
	*		30. Name and address of person who	completed cause of de	ath (Item	23a) (Type,	Print) Co	NSUE	6/	2vin	CZ, 14	40	
			6/05 Mon	prose re	not	Ro	eftrille	- ,	mp	20	シュ		
	Sta Registr	te ar	29b. Signature and title of certifier 30. Name and address of person who (105 Mon 31. Date filed (Month, Day, Year) MAY 16 2	.005 Janegistra	Saigna	1 Ap	all						
		100		1-6-2		1							

			For State Registrar	State of Ma	ryland /				ealth a D <i>eath</i>	and M	lental I		ene ()	05	18160
			1. Decedent's Name (First, Middle, Las	st)							2. Date of		Day	Van	3. Time of Death
Н	Physici		Abass Brahima K	aba							May		Day 2005	Year	11:23 A M
	/Medic Examin		4a. Fecility Name (If not institution, give				4b. City	Town, or	Location of	of Death			4c. Count	y of Deeth	
П			Holy Cross Hospit	al			Sil	ver S	pring	g			Mont	gomer	у
	Funeral		Social Security Number 6. S		(In yrs. last		If Unde Months		If Under Hours	24 Hrs. Min.	8. Date of	f Birth	(ear)	9. Birtho	olece (State or Foreign
н	Director		None	MM 2□F	0	Yrs.	0	1	5	44			2005		land
	pur *		Usuel Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation							1	0d. Inside City Limits
	eho	ō													1 ☐ Yes 2 No
	the N	Director	Maryland Prince G	eorge's	Laure	5T	10f Zi	o Code				10	g. Citizen of	What Cour	ntry?
	with w							708						ed Sta	•
	heath In	era	13402 Arden Way A	12. Was Decedent E	ver in U.S.	13.1			spanic Ori	gin? (Spe	ecify Yes o	r No-	14. Ra	ce - Americ	can Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or items 23e or 28e-f ehow empiriants of other traumatic event, the Medical Ezationer install be incitified at once.	by Funeral	1 XNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	0	1	if Yes, spe 1 ☐ Yes		n, Mexicar Specify:	i, Puerto	Rican, etc	.)	Specia		
Ş	thou stura	ed	15. Decedent's Ed	lucation	10	6a. Dece	dent's Usu	al Occupa	ation			10	6b. Kind of E		
7	n n	Completed	(Specify only highest gra	de completed) College (1-4or 5-	4)	(Give	kind of w DO NOT i	ork done d ise retired	luring mos)	t of worki	ng				
212	d with	E	0	0011 09 0 (1 407 0	′	Nor	1e						None		
9	e file al Hy othe vent,	Be	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Mi	ddle, Ma	aiden Surnai	me)	
<u>a</u>	Ments Ments Mrked Mrked	10	Abass Diakity Kab						Chri	stina	a Mol	oma	Trye		
Maryland 21215-0036	2 shc and is m		19a. Informant's Name/Relationship (City or Town		
	and lealth m 27		Abass Diakity Kab	a / Father	20b. Place				-	4.4	-	-	L, MD Dc. Location		
Baltimore,	Pages 1 nent of h ant: if ite		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif.		Mary I Memor	and	natory or Nati	other plac onaT		1ay 1 2005	.4,		aurel		
Balt	Departr Imports eny inj		21. Signature of Funeral Service Liber		00956	T	hibad	leau	s of Facili Mortu vel	iary	Serv	ice,	P.A. ilver	Sprii	20906
			23a. Part1. Her the is ase, or come shock, or hear ailure. List only												Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. PULMONAI			SIA								2 DAYS
	Examiner			Due to (or as a			NEC /	.m 01	T 177771						E LIEBVO
		ē	Sequentially list conditions, if any, leading to immediate	b. RUPTURE			NES E	11 21	WEEK	(5					5 WEEKS
	uted	m in	cause. Enter Underlying Cause (Disease or injury that initiated events	EXTREME	PREMA	TURI	ΤY								2 DAYS
Ć.	execut an an rial-tr	Examin	resulting in death) Last	Due to (or as a	consequen	ce of):									
8760,	icate be executed physician and s the burial-transit	dicai		d											
9	ntifica ng ph as th	Med	IF FEMALE.										-1		
Box	The law requires that the death certifi tte has been signed by the attending I page 2 should be detached for use as	by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 X No	23c. If yes, outcome of Live birth and Pregnant at 9 Unknown	2 ☐ Fetal dea	ath 3	Ectopic p	oregnancy pecify)						ate of deliver	ery Day Year
P.O.	at the by th	hys	9 ☐ Unknown					2.5					_		
Records, I	quires than signed uld be de		Part II. Other significent conditions of	ontributing to death bu	ut not resultin	ig in the u	nderlying	cause give	en in Part I						he cause of death? pably 4 Unknown
CO	s been si	Completed									24a.	Was an	24b.	Were auto	psy findings available
Re	The la	mo									1 U Y	autopsy perform	ed?	death?	mpletion of cause of
ţa	10	0	25. Was case referred to medical						26. Place	of Death	(Check o			7 7 7 7 7 7	20110
\geq	Physician: r this certificanal director.	0	examiner? 1 □ Yes 2 💢 No	Hospital: 1 X Inpatie	nt 2 ER	Outpatier	nt 3 🗆 0	OA Othe	9r: 4 🗆 No	ırsing Ho	me 5 🗌	Residen	ice 6 🗆 Ot	her (Specif	(y)
o uo	ding Afte fune	tion: T	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injur (Month, Day	y Year) 28	b. Time o	f M	28c. Injury Work	/ at ⟨? Yes 2 □		28d. Desc	ribe hov	v injury occu	rred	
Division of Vital	P C C C	Certification:	3 Suicide 6 Could not be determined		iry - At home :. (Specify)	, farm, str	eet, facto	ry, office				on (Stre r Town,		ber or Rura	il Route Number,
_	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying Pt (Check only one)	nysician: To the best of miner: On the basis of and manner sta	of my knowled examination ted.	dge, deat and/or in	h occurre vestigatio	d at the tim	ne, date ar pinion, dea	nd place, ith occurr	and due to ed at the t	the cau	use(s) and m	nanner as s , and due to	tated. o the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier				29	c. License	e number			29	d. Date sign	ed (Month,	Day, Year)
)	. >- 0		1 Sect	1	. /	2		D5350	19			1/2	lay 11	. 200	5
			30. Name and address of person who	completed cause of de	eath (Item 23	ia) (Type.						1 1.	,	, 200	
			Janet K. Hino, M	.D. 1500	Forest	: Gle	n Ro	ad S	ilve	r Spi	ing,	MD	20910		
- (A)	Sta		31. Date filed (Month, Day, Year)		ar's Signature										
5	Regist	rar	MAY 16	2005	N N	19									

			1 - For State Registrer	State of M	laryland		artmen rtificat			and M		giene	5	18161
	Physic	ian	1. Decedent's Name (First, Middle, La		1 1	!	</td <td>)</td> <td></td> <td></td> <td>2. Date of De</td> <td>Day</td> <td>Year</td> <td>3. Time of Death</td>)			2. Date of De	Day	Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, giv	eRT K		MAN	1	Town, or	Location of		MAT	4c. County	of Death	M SOA M
4	LAdillii	iei	NEZTH AZULL		EPITT	AL			ell-			Ann	- A	BUNDEL
	Funeral		5. Social Security Number 6. S	Sex 7. A	ge (In yrs. Ia	ast birthday)	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	ay, Year)	Cour	
	Director		218-20-4737 Usual Residence of Decedent	X	74	Yrs.					JULY 5	5, 1930	MARY	TLAND
	show		10a. State 10b. County		10c. City	, Town or Lo	cation					<u> </u>	1	0d. Inside City Limits
	e Mar sa-f si	ctor	MD QUEEN	ANNE	CF	ENTREV	ILLE							1 XYes 2 ☐ No
	with th	Director	10e. Street and Number				10f. Zip					10g. Citizen of	What Cour	ntry?
	eath y	eral	426 RAILROAD AVE	NUE 12. Was Deceden	t Ever in U.S	S 13		2161		nin? (Sne	cify Yes or No	USA 14 Bac	e - Americ	ean Indian
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itam 27 Is markad other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 X Divorced	Armed Forces 1 Yes 2 1 If Yes, Give Year or Dates	? [No		If Yes, spec	ofy Cuba	n, Mexican	, Puerto I	Rican, etc.)		ck, White,	
21215-003	2 hou	ted	15. Decedent's E	ducation		16a. Dece	dent's Usua	al Occupa	ation			16b. Kind of B		
215	ithin 7 19. 18. "n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or	5+)	`life.	kind of wor DO NOT us	e retired))	or workii	ng			
	filed w Hygier Sthar th		17. Father's Name (First, Middle, Last	-0-		W	ATERM	AN	10 14-45-	de Nome	(First Middle	SEAFO		
Maryland	2 should be filed withir and Mental Hygiene. Is markad othar than aumatic evant, I're Ms	To Be	FLOYD BERNARD K		R.							, Maiden Suman TH JACKS		
ary	should and Men s marka umatic	-	19a. Informant's Name/Relationship (19b. Maili	ng Address	(Street a	ind Numbe	r or Rura	l Route Numb	er, City or Town,	State, Zip	Code)
	ss 1 and 2 of Health a itam 27 is rothar trai		ROSE ELIZABETH CL	OUGH/SIST					VENUE	_		LLE, MD	2161	7
Baltimore,			20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special		Ce	ace of Dispo emetery, cred ESTERF	natory or o	ther place			1-2005	20c. Location -	•	
Balt	permit. Page Department of Important: If any injury or 2009.		21. Signature of Funeral Service Lice	Rac	ota	/ FE		, HEL	FENBE	IN &		M FUNERA		Æ, P.A.
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that cause one cause on each	the death									Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			SIA.								Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a										
		in the	Sequentially list conditions,	b. Due to (or a	s a consequ	ence of):								
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,									
o,	be executed ician and burial-transit	Exa	resulting in death) Last	Due to (or a	s a consequ	ence of):								
8760,	cate be ex ohysician the buria	dical	(d					***					
9	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Med	IF FEMALE:	22a If was autoom										
Вох	attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 Live birth 4 Pregnant	2 Fetal	death 3[Ectopic pro					23d. Dai	e of delive nth	ry Day Year
o.	t the deby the tached	Jask	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	11 (MIIO OI QO	addi 3L	J Other (sp	acity)						
4	res that igned b be deta	by Pł	Part II. Other significant conditions	contributing to death	but not resu	tting in the u	nderlying ca	ause give	n in Part I.		23e. Did t	obacco use cont	ribute to th	e cause of death?
rds	w require been sig should b	ed b									1 🗆 '	Yes 2 □ No	3 🗆 Prob	ably 4 Unknown
Records,	has be	Completed									24a. Was	an 24b.	Vere autor	osy findings available
<u>=</u>		Con			,						perfo	rmed?	leath?	25 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	r		(Check only o			
of	Phys	To To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 La mpat		P/Outpatier 28b. Time o		Bc. Injury	4 🗆 Nui			dence 6 Oth		")
on	Attanding F r death. actor: After by the funera	atlor	1 ■ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Inj (Month, D	ay Year)	Injury	М	Work	? ′es 2 □ N			,,		
Division	or Attandii after death. Diractor: A in by the fu	Certification:	3 Suicide 6 Could not be determined	289. Place of it	njury - At hor tc. (Specify)	me, farm, str	eet, factory	, office		2	8f. Location (3 City or Tox	Street and Numb wn, State)	er or Rura	Route Number,
	spital or At ours after o heral Dirac filled in by		29a. Certifier 1 Certifying Pt	veicier: To the h	t of mul	ulades des		n4 4b - '	- d-1- :	d alo	and divine to the			-Ad
	To tha Hospital or Attanc within 24 hours after death To the Funeral Diractor: completely filled in by the	edical	(Check only one)	nysician: To the bes miner: On the basis and manners	of examinati	vieage, deati ion and/or in	occurred a vestigation,	in my op	e, date and inion, deat	i piace, a h occurre	and due to the	cause(s) and ma date and place,	nner as st and due to	ated. the cause(s)
	To the To the Comp	Ň	29b. Signature and the of certifier	0		.00.	29c	. License	number	>		29d. Date signed	i (Month, I	Day, Year)
6) 00		1 2 We	20		mo		بى بور 	>، ۴۷			ALYA !	7 36	200
(1)	417		30. Name and address of person who	completed cause of			Print)	4	e Ce	n s.	Burn	e mi	> 2	1661.
2	Sta Registi	4	31. Date filed (Month, Qay) Year)	2005 32. Rec	rar's Signati	dr.	Soul							

			For State Registrar	State of Marylan		artment of H		ental Hygier	- 000	18162
	Physici /Medic		Decedent's Name (First, Middle, Las JOHN	JOSEPH		KRAFT		2. Date of Death Month Da	2005	3. Time of Death 443 PM
	Examin		4a. Facility Name (If not institution, give	street and number) (n	ter	4b. City, Town, or Bel	Cur Location of Death	40	County of Death	2
Ī	Funeral Director		210#25#32TT -	7. Age (In yrs. 54	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year 11/14/19	9. Birth Coul 50 Ms	place (State or Foreign ntry)
	aryland show	2	Usual Residence of Decedent 10a. State 10b. County MD Hari		y, Town or La		Jarretts	erillo		10d. Inside City Limits 1 ☐ Yes 2 No
	th the M or 28a-f	Director	MD. Har	ora		10f. Zip Code	oarre cus		itizen of What Cou	
	sath wil		3405 North 1			Man Danidani of II	21084	4. V N-	United	
5-0036	be filed within 72 hours after death with the Maryland Hygiene. d other then "neturel", or tems 23e or 28a-f show event, It e Modical Examinar must be notified a	by Funerai	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2) No	lispanic Origin? (Spec an, Mexican, Puerto Ri Specify:	ican, etc.)	14. Race - Americ Black, White,	
215-0	hin 72 ho a. an "netur Modell	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of working	16b. F	Kind of Business/In	dustry
12121	filed with Hygiene other thei		12 17. Father's Name (First, Middle, Last)	Ó	Rece	eiving ((First, Middle, Maider	Shipp	oing
aryland	e d la be	To Be		John Kr	aft .	Jr.	Anna		bara	Butt
	and and le m		19a. Informant's Name/Relationship (7							Code) 21084
e, ⊠	of Health item 27 other tr		Laura V. Kraft 20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of	Furnace Da		.rrettsv .ocation - City or To	rille, Md.
ltimore,	0 0		1 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify	Hemoval from State	-	natory`or other place sville (/2005 Ja	rrettsv	ille.Md.
Balt	permit. Pag Department Importent: I any injury o once.		21. Signature of Funeral Service Liken	100 H	111 22	2. Name and Addres	ss of Facility Ja	rrettsvi	lle, Ma	ryland
	TD = # C		23a. Part1. Enter the disease, or comp	olications that caused the death			rtz & Sol		1 Home	Approximate
Н	nysician		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. arteriosch	Protie	Corda	ovasculi	or dise	ase	Interval Between Onset and Death
	/Medical Examiner			Due to (or as a consequ	uence of):					,
, ,	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
68760	icate be physici s the bu	dicai		d						
O. Box 6	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)	,		23d. Date of delive Month	ery Day Year
P.	res that th igned by be detack		Part II. Other significant conditions of	ontributing to death but not resu	ulting in the ur	nderlying cause give	en in Part I.	23e. Did tobacco	use contribute to the	ne cause of death?
ecords,	w requires been sign should be	ted by	None					1 Yes 2	□No 3□Prob	ably 4 Unknown
_	The larate has	Completed						24a. Was an autopsy performed?	prior to co	psy findings available mpletion of cause of 200 No
Vital	sicien: Th certificate rector, pag	o Be	25. Was case referred to medical examiner?	Hospital:	PR/Outpatien	t 3 DOA Othe	26. Place of Death (
ion of	or Attending Physicien: ther death. Director: After this certific in by the funeral director.	-	27. Manner of Death Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 🕱 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun	4 Nuising Home	e 5 ☐ Residence 3d. Describe how inju		y)
Division	spital or Atteno ours after death nerel Director: filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, str	eet, factory, office	28	If. Location (Street ar City or Town, State	nd Number or Rura e)	l Route Number,
	Fu th	edicai	29a. Certifier 1☐ Certifying Phy (Check only one) 1☐ Medicel Exem	vsicien: To the best of my knowiner: On the basis of examination and manner stated.	wledge, death tion and/or inv	n occurred at the tim restigation, in my op	ne, date and place, an pinion, death occurred	d due to the cause(s d at the time, date and) and manner as si d place, and due to	tated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	a. Ul Ani.	F	29c. License	14206	29d. Da	ite signed (Month,	Dey, Year)
	15		30 Name and address of person who of	completed cause of death (Item	23a) (Type,	HOLABIRI	DAVE B	ALTO M	1 2022	2
<i>E</i>	Sta Registr	76	31. Date filed (Month MAY 3) 1 2	005 32. Agistrar's Signa	ture	north				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 15

		1 - For State Registrar	State of Ma		epartment of I Certificate of			Reg. No.	5 1	3 6 3
Physic	ian	Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Year	3. Time of Death
/Medi	cal	Vivian Lucille 4a. Facility Name (If not institution, give s			4h City Town	or Location of De	May	13, 20	05 ty of Death	3:49 p M
Exami	ner	Lorien Nursing Hom			Columbia		uiii	Howa	_	
Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birth		If Under 24 H		th		lace (State or Foreignitry)
Director		3/7-40-96/4	м 2∛О F	90 Yr	s. World's Days	Tiours IVII	May 8,			iesota
and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				1	0d. Inside City Limits
Mary -feh	ţ	Maryland Howard		Ellicott	: City					1 ☐ Yes 2 ☐XNo
h the	Directo	10e. Street and Number		LITTEOU	10f. Zip Code			10g. Citizen of	f What Cour	itry?
23a c	ai	9922 El Dee Drive			21042			USA		
DESILITIOTE, INTERVIGITION ZINISTONOSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-1 ehow any injury or other traumatic event, the Medical Examinar must be notified at some.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 XN If Yes, Give Year or Dates:		13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 X No		(Specify Yes or No erto Rican, etc.)	Spec	ace - Americ ack, White, ify: Whit	etc.
2 hou		15. Decedent's Educ	ation	16a. D	ecedent's Usual Occu	pation	,.	16b. Kind of		
nd ZIZID-UU30 e filed within 72 hours af al Hygiene. other than "natural", or vent, the Madical Exon	Completed	(Specify only highest grade	completed) College (1-4or 5-	+)	Give kind of work done fe. DO NOT use retire cher	during most of w	vorking	Educa	tion	
be filed tal Hygi od other	6)	17. Father's Name (First, Middle, Last)	** 1				lame (First, Middle		ime)	
Maryland of 2 should be file the and Mental Hy free marked oth treematic event	To B	Christopher Charles 19a. Informant's Name/Relationship (Ty)		10h A	Mailing Address (Street	1	essie Dur		- Ctata 7i-	Codel
Man d 2 st ith and tth and 27 is r	ì	Joan Leslie Doerr/d						,		
ore, M ss 1 and 2 of Health Iltem 27 r other tra		20a. Method of Disposition		20b. Place of D	2 E1 Dee I disposition (Name of crematory or other pla		ay ^{pat} 16,	20c. Location		
Pages Pages nent of int: If It		1 ☐ Burial 2 🖾 Cremation 3 ☐ R. `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		idel Cremat	/	2005	Odento	n, Mar	yland
Baltimore, permit. Pages 1 ar Department of Hea Important: if Item; any injury or other		21. Signature of Funeral Service License	e Att	MO1251	22. Name and Addre Going Home Beverly L.	ess of Facility Cremat	ion Servi	ce P.(). Box	784 MD 2102
		23a. Part1. Enter the disease, or complications shock, or heart failure. List only on	cations that caused e cause on each lin	the death. Do no	t enter the mode of dy	ng, such as card	lac or respiratory a	rrest,	3 4 4 4 4	Approximate Interval Between Onset and Death
Fnysician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	Due to (or as a	consequence of consequence of	A Ension	ent l	TAI lUR	E		
ertificate be executed ling physician and se as the burial-transit	edicai	resulting in death) Last	Co	consequence of	:					
that the death certification of the attending detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth : 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	у			ate of delive fonth	ny Day Year
cords, F.O. w requires that the been signed by the should be detache	by	Part II. Other significant conditions con	tributing to death bu	t not resulting in t	ne underlying cause gr	ven in Part I.				ably 4 Donknown
The law ate has t	Completed						24a. Was auto perfo 1 ☐ Yes		. Were auto prior to con death? 1 \(\text{Yes}	psy findings available npletion of cause of
Physician: The Physician: The Chiscontificate ral director, page	Be	25. Was case referred to medical examiner?	ospital:		0.	200	eath (Check only			
Attending Physical Grant Color	ition; To	1 Yes 2 No 27. Manner of Death 1 Manural 5 Pending 2 Accident investigation	1 ☐ Inpatie 28a. Date of Injur (Month, Day		ne of 28c. Injury Wo	4 mursing	Home 5 Resi 28d. Describe	dence 6 🗌 Or how injury occu		/)
DIVISION ospital or Attending hours after death. uneral Director: Afte	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, farn . <i>(Specify)</i>	n, street, factory, office		28f. Location (City or To		nber or Rura	l Route Number,
A 4 17 0	edicai	(Check only 2 Medical Examile one)	ner: Dn the basis of and manner sta	examination and/ ted.	death occurred at the to investigation, in my	opinion, death oc	ccurred at the time,	date and place	, and due to	the cause(s)
To the within 2.	Σ	29b. Signature and title of certifier	m		29c. Licen	se number		29d. Date sign	ed (Month,	Day, Year)
		V	///		D	17107		7/1	9/08	
E.G		30. Name and address of person who co	mpleted cause of de	eath (Item 23a) (T	umbiA	MD	21045	_ Will	14 m	DAWAY
	ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature						

		riedsi	State of Ma				Health and M	-		•	
		1 - State	State of Ivia	aryland		artment of r rtificate of		_	/	11115	18164
	-	Registrar 1. Decedent's Name (First, Middle, L	ast)		00.	Timeate of	Deain	2. Date of De	Reg. No ath		3. Time of Death
Physic	ian	Harriet S. Le						Month	Day		
/Med Exami		4a. Facility Name (If not institution, g				4b. City. Town.	or Location of Death	May	15,	2005 County of Dea	12:20 A M
- Exaim	Hei	42 Shamrock Ci					inster			Carrol1	
Funera			Sex 7. Age	Θ (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bin (Month, Da	th		thplace (State or Foreign ountry)
Directo		066-10-6406	^{1□ M 2} XF 89		Yrs.	Months Days	Hours Min.	July 20		915 Ne	w York
pu 🕽		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	nation					40d Inside City Limite
laryla sho	70		roll		estmi						10d. Inside City Limits
the M	Director	10e. Street and Number		<u> </u>		10f. Zip Code			10a Cit	izen of What Co	
death with the Maryland ms 23s or 28a-1 show rmat be rediffed at	Ö	42 Shamrock C	irala				157				tates
leath ns 23	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S	3. 13.			ecity Yes or No		14. Race - Ame	
ig 22 23	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 Yes 2 1	No			Hispanic Origin? (Sp pan, Mexican, Puerto	Rican, etc.)		Black, Whit	
-UU36 hours after tural; or Ite	by	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:		ŀ	1□Yes 2XNo	Specify:			Specify: W	hite
Maryland 21215-UU35 d 2 should be filed within 72 hours af th and Mental Hygiene. 77 is marked other than "natural", or treumatic event, the Modical Event	eted	15. Decedent's (Specify only highest of			16a. Dece	dent's Usual Occup	pation during most of work	rina	16b. K	ind of Business	/Industry
d Z1Z13- fited within 72 Hygiene. other then *net ent, the Medic	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	IITO.	DO NOT use retire	(d)				
filed v Hygiei ther ti		12 17. Father's Name (First, Middle, La.	aet)	1	Cont	ract Adm:	inistrator				vernment
anc lbe findal Hed of	Be	Louis	J.	Sher	win		18. Mother's Name	,	Maiden	,	tter
Maryland 21215-0U36 d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. 7 is marked other than *natural*, or items 23s or 28a-1 show treumatic event, the Medical Examinar must be notified at	2	19a. Informant's Name/Relationship		- Silei		no Address (Street	t and Number or Run		ar City o		
Mar har lee		Marybeth Leopol		or			Circle/We				
or other tree	-	20a. Method of Disposition	u / udugire	20b. Pla	ace of Dispo	osition (Name of matory or other pla		Date		cation - City or	
		1 Burial 2 Cremation 3 '4 Donation 5 Other (Spec				,	den 05/17	7/2005	Fred	derick 1	Maryland
₽ 3 5 2 3 3		21. Signature of Funeral Service Lic			2	2. Name and Addre	ess of Facility St	auffer	Fune	ral Hom	nes. P.A.
Depariment Department		Baymons	Belex	2000			sumtown P				
Enga		23a. Part1. Ever the disease, or co shock, wheart failure. List on	mplications that caused	the death.	. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory ar	rrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition				RITIO					Onset and Death
/Medical		resulting in death)	Due to (or as			KIIIO	70				WELKS
Examiner		Sequentially list conditions.	b								
be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	ence of):						
68 / 6U, Ificate be executed physician and is the burial-transit	xan	that initiated events resulting in death) Last	c Due to (or as :	a consequ	ence of):						
Sician b buria	calE		·								
G&/ ificate g phys			0.								
HECORIS, P.O. BOX 68 The law requires that the death certifica te has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			7-				23d. Date of de	livery
death death death	Cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at]Ectopic pregnanc] Other <i>(specify)</i> _	у			Month	Day Year
at the de	hys	9 Unknown	9□ Unknown					4 4 5			
IS, P	by F	Part II. Other significant conditions			lting in the u	nderlying cause gr	ven in Part I.				the cause of death?
cord: w require been sig		DEG	PRESSION	J				1 🗆 1	Yes 2	No 3□Pr	obably 4 Unknown
Hecords, he law requires t e has been signe ge 2 should be	Completed							24a. Was	SV	24b. Were at	utopsy findings available completion of cause of
	Con							perfo 1 ☐ Yes	rmed? 2 XNo	death?	2 No
VITAL IN sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Magazitali				26. Place of Deat	h (Check only o	ne)		
Physi this of this of	To	1 Yes 2 No	Hospital: 1 ☐ Inpatie		R/Outpatier 28b. Time o	IL 3LL DOX	her: 4 Nursing Ho				city)
ding F	lon	1 Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	y Year)	Injury	Wo	rk?]Yes 2 □ No	28d. Describe h	iow injur	у осситва	
DIVISION OF I or Attending Phy after death. Director: After this Lin by the funeral d	Certification:	3 Suicide 6 Could not	be 28e. Place of Inju	ury - At hor	ne, farm, sti	reet, factory, office		28f. Location (5	Street an	d Number or Ri	ural Route Number,
after after Dire	erti	4 Homicide	building, etc	c. (Specify))			City or Tox	vn, State)	
DIVISION Of VITA To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifying I	Physician: To the best of	of my know	rledge, deat	h occurred at the ti	me, date and place,	and due to the	cause(s)	and manner as	s stated.
he Ho n 24 i ne Fu	Medical	(Check only 2 Medical Ex	aminer: On the basis of and manner sta	f examinati	on and/or in	vestigation, in my	opinion, death occurr	red at the time,	date and	place, and due	to the cause(s)
To the To the comp	×	29b. Signature and title of certifier	00/		0	29c. Licens				e signed (Mont	
/		Uncent	Hio	eed	2 mi		1663		<	05/16	105
5		30. Name and address of person					AT Emi		~~		
		31. Date filed (Month, Day, Year)	2005 32. Resistra			n	ECTMIN	CTER	n	0 21	157
S Penis	tate trair	MAY 1	2005	July and a		2000					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrer AMEND#31,penMbCc5/13/05,DFS,McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 0/23:4 JYLVIA 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TAKOMA PARK, MD MONTG OMERY NASHINGTON ADVENDST HOSPITAL 7. Age (In yrs. last birthday)

Orange (In yrs. last birthday)

Orange (In yrs. last birthday)

Months Days Hours Min. June 17, 1921 5. Social Security Number 6. Sex Birthplace (State or Foreign
Country) **Funeral** 016-16-7649 1□M 2√2F New York Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits a 23a or 28a-f show Maryland Montgomery Chevy Chase Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3811 Inverness Drive United States 20815 Funerai 12. Was Decedent Ever in U.S. Armed Forces ↓ 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status I've Madical Examiner: 1 ☐ Never Married 2 ☐ Married ŏ 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: pieted by Specify: White 3X Widowed 4 □ Divorced natural 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Com lith and Mental Hygier 27 Is marked othar the r traumatic evant, II. 12 Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Bach Ida Sher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If itam 27 Is any injury or other trau 10633 Canterberry Rd. Fairfax Station, Va. 22039 Patricia L. Kent -daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State King David Memorial Cdn. 5/13/2005 Falls Church, Va. X Burial 2 Cremation 3 Removal from State 4 □Donation 5 □ Other (Specify) 21. Signature of Funer I Prvice Litersee 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Md. Momas > 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARDIOGE NIC Pnysician /Medical Examiner RONARY Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by REW NAL 1 Yes 2 No 3 Probably 4 Onknown VRU 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 1 Yes .3∆W0 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes . **₹**Z No Inpatient 2 ER/Outpatient 3 DOA 27. Mayor of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed Box 68760. attending physician for use as the buria signed by the a Records, P.O. Division of Vital or Attanding Physicisn: After s after dea... ral Director: Aftr pelli a Funaral within 2 To tha

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

20

edicai

State Registrar

DIO 31. Date filed (Month, Day, Year)

INZWI NYRW

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 1600 Carroll Ave . Takoma Park, Nud. 20912

			For Stete Registrar	State of Mar		artment of H			giene Reg. No.	005	181	66
			1. Decedent's Name (First, Middle, Las	st)				2. Date of De	ath Day	Year	3. Time of	Death
	Physici: /Medic		Thomas G. Laughl	in						2005	1:00	рм
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Deal	th	4c. 0	County of Death		
			Randolph Hills N	Jursing Home	e	Wheato	n			ontgomer	ry	
	Funeral		5. Social Security Number 6. S	ex 7. Age (☑M 2□F	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da	y, Year)	9. Birthp Cour	place (State ontry)	or Foreign
	Director		438-24-2039	X 2	80 Yrs.			Nov.18,	1924	Washi	ngton	,DC
	and	1	Usual Residence of Decedent 10a. State 10b. County		IOc. City, Town or Lo	cation				1	0d. Inside C	ity Limits
	Many f sho	ō	V1 1		IZ						1 🗌 Yes	2 € No
	28a	Director	Maryland Montgom 10e. Street and Number	lery	Kensingt	10f. Zip Code			10g. Citiz	en of What Cour	ntry?	
	3a ol	D	3355 University E	Slud West	#107	208	9.5			USA		
	death rms 2	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.1	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (5	Specify Yes or No	. 1	4. Race - Americ Black, White,		
စ္	or Ita	F	1 XNever Married 2 ☐ Married	1 ⊠ Yes 2 ☐ No			Specify:	to Thoan, 6to./		Specify:	etc.	
ဗ္ဗ	72 hours after death with the Maryland natural', or Itams 23e or 28e-f show dieal Examinations to institled at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	WW II					Whit		
<u>5</u>	natu	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	furing most of wo	orking	16b. Kin	d of Business/In	dustry	
12	within the same.	ш	Elementary/Secondary (0-12)	College (1-4or 5+) 5+			,		T			
2	Hygie Hygie thar int,	e Co	17. Father's Name (First, Middle, Last)		ALL	rney	18. Mother's Na	me (First, Middle,	Law Maiden S	Sumame)		
Maryland 21215-0036	d be antal ced o	00	James Laughlin				I nov V	ictoria	Doto	***		
<u> </u>	mark mati	2	19a. Informant's Name/Relationship (19b. Mailir	ng Address (Street a					Code)	
N S	ulth ar 27 ia r trau		Gordon Ovington/I	Personal 1	Rep. 17813	Park Mi	11 Drive	Rocky	:11e	.Marylar	ad 208	55
ō,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or Items 23a or 28a-1 show amy injury or owner traumatic event, the Medical Examination at the nutilised at ance.		20a. Method of Disposition		20b. Place of Dispo			Date		eation - City or To		25
Ë	Page onto		1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Gate of I	leaven emeterv		16,2005	S11v	or Sprin	or Mar	t-ce fy
Baltimore,	mit. Dartm Sorta		21. Signature of Funeral Service Licer		22	. Name and Addres	s of Facility				in a man	y I raini
m	8 9 E 8		James & C	Lebor		ancis J. 00 Univers					MD 20	901
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	ne death. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory a	rrest,	- opr xm	Approximat Interval Bet	te tween
	Pnysician :		Immediate Cause (Final disease or condition		e Renal Di	sease					Onset and	Death
	/Medical		resulting in death)	u	consequence of):						2 2 15 200	
	Examiner		Sequentially list conditions.	b								
	sit ad	ine	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a	consequence of):							
	and and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):							
8760,	death certificate be executed e attending physician and nd for use as the burial-transit				, ,							
687	phys phys s the	an/Medical		_ d								
	h certific anding p use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					2	3d. Date of delive	ary	
Вох	death e atter	icla	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at ti]Ectopic pregnancy] Other (s <i>pecify)</i>			4	Month	Day '	Year
0	t the de by the a	hysici	9 □ Unknown	9□ Unknown								
ري ص	es tha igned be det	by P	Part II. Other significant conditions of	contributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco us	se contribute to ti	ne cause of o	death?
ğ	w require been sig should b		Diabetes Mellit	us Type II				1 🗆 '	Yes 2□]No 3 ☐ Prob	nably 4 🙀	Jnknown
Vital Records,	The law requires that the te has been signed by the bage 2 should be detache	ompleted						24a. Was		24b. Were auto	psy findings impletion of c	
Ä	The late happage							perfo	rmed? 2√√ No	death? 1 ☐ Yes		2200 0
Ita	ician: T certifical rector, p	BeC	25. Was case referred to medical examiner?				26. Place of De	ath (Check only o				
of V	d is	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient			442) (40/3///g	Home 5 Resid			y)	
D L		on:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Worl		28d. Describe	how injury	occurred		
Sio	Attending r death. actor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not b		Albana fam at		Yes 2 □ No	29f Location (Stroot and	f Number or Rura	al Pouto Alum	nhor
Division	after death Diractor:	ertification;	4 ☐ Homicide determined	building, etc.	y - At home, farm, sti (Specify)	eet, ractory, onice		City or Tox	vn, State)	Trumbur of Flare	11 110010 11011	1507
	urs urs arel	O	29a. Certifier 1 X Certifying Ph	nysician: To the best of	mv knowledge, deat	h occurred at the time	ne, date and place	e, and due to the	cause(s)	and manner as s	tated.	
	To the Hospitel or within 24 hours afte To the Funerel Dirt completely filled in the Funerel Dirt completely	edical		miner: On the basis of e and manner state	xamination and/or in							3)
	To th within To th	Me	29b. Signature and title of certifier	D 1	//	29c. License	e number		29d. Date	signed (Month,	Day, Year)	
)	5+1		1 (Com to	(I am	all w.	D 5	2261		Mav	13, 200	5	
	フリリ		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type, Hugo Ciro	Print)						
			Alan R. Segal,	M.D. 1517	Hugo Circ	le Silve	er Sprin	g,Maryla	nd	20906		
	Sta		31. Date filed (Month, Day, Year) MAY 1 6 20	2. Registrar	s Signature	Se la la la la la la la la la la la la la						
	Regist	reli	MINI TO SO	AND PORTOR OF THE PARTY OF THE	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Dav Vasi **Physician** A^{M} 12 2005 May 1:10 John J. Lapp /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery 18317 McKernon Way Poolesville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 59 219-46-5384 8, Director Jan. 1946 Washington, Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or itema 23a or 28a-f show the Medical Examination and the natified at 1 XYes 2 ☐ No Poolesville Director Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20837 18317 McKernon Way Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Self Employed permit. Pages 1 and 2 should be fited to Department of Health and Mental Hygie Important: If Itam 27 is marked other 1 any Injury or other traumatic svent, Ib. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lillian Casterline Claude Lapp, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18317 McKernon Way Poolesville, Maryland 20837 Linda LeBlanc / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State May 16, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation Silver Spring, MD Gate of Heaven Cemetery 5 Other (Specify) 2005 22. Name and Address of Facility 21. Signature of Funeral Service Licensee DeVol Funeral Home Gaithersburg, ND 20877 10 E. Deer Park Dr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MECANOMA YEAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease richar) that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) ettending physician Division of Vital Records, P.O. Box 68760. by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year ö in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the detached 9 Unknown 9 Unknown Ś Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed 99 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No 2 X No Physicien: To the Funerel Director: After this certific completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To 1 ☐ Yes 2 X No 4 Nursing Home 5 Residence 6 □Other (Specify) 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27 Manner of Death 28d. Describe how injury occurred or Attending 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours e To the Funerel (1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and

Registrar

DHMH 17 Rev 1/2001

State

10

9707 Medical Center Drive #300

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

2005

edistrar's Signa

Paul Thambi.

16

31 Date filed (Month, Day, Year)

DO061083

MAY 12, 2005

Rockville, Maryland 20850

			1 - For State Registrar	icuoc	State of M		d / Depa	artmen	t of H		and Me	ental Hy		211115	18	168
			Decedent's Name (First, I	Aiddle, La	st)	-						2. Date of De	ath			of Death
	Physici		Mary	A1.	ice		Lake					Month May 12	Da 2	y Year 2005	5:15	рм
	/Medic Examin		4a. Facility Name (If not inst					4b. City,	Town, or	Location of	of Death			. County of Dea		
	LAGITIII	CI	Holy Cross R	ehah	& Murcir	na Cer	nter	B	urto	nsvil	10			Montgom	lerv	
	Funeral		5. Social Security Number	6. 9			last birthday)	If Under	1 Year	If Under		8. Date of Bir (Month, Da			rthplace (State country)	or Foreign
	Director		213-40-7919	1	□M 2%□F	62	Yrs.	Months	Days	Hours		Month, Da July 28			ountry) shingto	
_	ō		Usual Residence of Decede													
	nylar how	_	10a. State 10b. Co	unty		10c. Cit	y, Town or Lo	cation							10d. Inside	
	Ma Ma	cto	Maryland Mo	ntgo	mery		Wheat	on							1 ∐ Y€	s 2 X No
	death with the Maryland rms 23a or 28e-f show rmst be notified at	Director	10e. Street and Number					10f. Zip	Code				10g. Ci	tizen of What C	ountry?	
	th w		12101 Vall	eywoo	od Drive			2	0902					USA		
	swe swe	Funeral	11. Marital Status		12. Was Deceden Armed Forces	t Ever in U	.S. 13.	Was Deced	dent of Hi	ispanic Ori	gin? (Spec	cify Yes or No Rican, etc.)	-	14. Race - Am Black, Whi		
õ	or fit	Y.	1 Never Married 2		1 Tes 2 2			1 ☐ Yes		Specify:		,			hite	
9500-612	urel',	d by	3 ☐ Widowed 4 🏝 Dive		Year or Dates	:										
γ̈́	"net	Completed	15. Dec (Specify only I	edent's Ed lighest gra	ducation ade completed)		16a. Dece (Give	dent's Usua kind of wo	al Occupa rk done d	ation during mosi i)	t of workin	g	16b. K	(ind of Business	s/Industry	
Z	withir sne. then	ш	Elementary/Secondary (0.	12)	College (1-4or	r 5+)	1	shier	se reureu	,				200021	Ctoro	
N	iled Hygie ther nt, II		17. Father's Name (First, Mi				1 04.	311101		18 Mothe	ar's Name	(First, Middle		rocery	Store	
yland	t be intal l	Be	Dennis Cle										, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	7 00111011107		
	hould d Me mark matic	2	19a. Informant's Name/Rela				10h Mailir	a Address	/Street			Laida	or City	or Town, State,	Zin Code)	
Z Z	d 2 sl th an 7 is r		Timothy C. L					_								
	1 an Heali em 2		20a. Method of Disposition	Owe/	Grandson	20b. F	Place of Dispo emetery, crer				Di	ate		MD 209		
ĕ	of History		1 ☐Burial 2 ☐ Crema			0				1	May	16,				
gaitimore,	it. Pi		`4 □ Donation 5 □ Oth		· ·	Gat	e of Hea			-	200	-		er Spri	ing, Ma	ryland
g	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene whether the meter of the marked other then "neture!, or flems 23a or 28e-f show amy hinty or other treumatic event, the Medical Examination must be notified at once.		21. Signature of Funeral Se	Pos	us fo		F1	afici O Un	iver	sity	ins E	Tuneral W, Si	. Ho	me Inc r Sprin	g,MD 2	0901
reu,	Physician /Medical Examiner phononcomplete phononco	Ilcal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	$\left\{ \right.$	b. Due to (or a c. Due to (or a d.	s a conseq	uence of): uence of):	all C	ell :	Lung	Cance	er			less 6 Mon	
O. BOX 68	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnal in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Feta	Ideath 3	Ectopic pi						23d. Date of de Month	blivery Day	Year
ras, r	requires that the een signed by th hould be detache	by	Part II. Other significant co Chronic Lun		-	but not res	ulting in the u	nderlying o	ause give	en in Part I.				use contribute t		_
Hecord	e la has	ompleted										24a. Was autor perio		prior to	utopsy finding completion of s 2 No	s available cause of
VITā:	ilcien: Th certificate rector, pag	se C	25. Was case referred to me	edical						26. Place	of Death	(Check only o				
>	Physicien: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ XNo		Hospital: 1 Inpat	tient 2	ER/Outpatier	nt 3□ DC	Othe	er: 4 🔼 Nu	rsing Hom	ne 5 Resi	dence	6 ☐Other (Spe	ecify)	
ion or	nding Ph ath, r: After th e funeral	on:		ending vestigatio	28a. Date of In (Month, D	jury ay Year)	28b. Time of Injury	M 2	8c. Injury Work	/at <br Yes 2⊡!	-	8d. Describe	how inju	ry occurred		
Division	To the Hospitel or Attending Physicien: within 24 hours after death, To the Funerel Director: After this certific completely filled in by the funeral director.	Certificat		ould not b etermined	286. Place of I	njury - At ho etc. (Specif	ome, farm, str	eet, factor	, office		2	8f. Location (. City or Tox	Street ai wn, State	nd Number or F e)	Rural Route Nu	mber,
	e Hospit 24 hour se Funer detely fills	edical	29a. Certifier 1 🔀 Cer (Check only 2 Mer	tifying Ph dical Exar	nysician: To the bes niner: On the basis and manners	of examina	wledge, death tion and/or in	n occurred vestigation	at the tim , in my op	ne, date an pinion, dea	d place, a th occurre	nd due to the d at the time,	cause(s date an	and manner a d place, and du	s stated. e to the cause	o(s)
	To the To the Comp	ž	29b. Signature and title of c	ertifier	1			290		number			29d. Da	ite signed (Mon		
	3		I find	M	Jun.	la			D3	35996				May 13	, 2005	
			30. Name and address of pe	rson who	completed cause of	death (Item	n 23a) (Type,	Print)								
			Linda M. Bu:	rrell	, M.D. 2	730 U	nivers	ity I	3lvd,	. W,	#400,	Wheat	on,	MD 2090	06	
; ; ;	Sta Registr		31. Date filed (Month, Day, MAY 1 (5 Maria	trar's Signa	ture form	Co.								-

			For State Registrar	State	of Maryla		artment of F rtificate of		d Mental Hy	ygiene	5	18169
	Dhamini		1. Decedent's Name (First, Middle,	Last)			-		2. Date of D	eath Day	Year	3. Time of Death
	Physici: /Medic		Bruce Geralo	l McCuli	lough				May May		005	5:00 A M
	Examin	er	4a. Facility Name (If not institution,		umber)		4b. City, Town, o			4c. County		1 1
_			2910 Conne Mara 5. Social Security Number	a Dr.	7 Ago //o.w	s. last birthday)	David	lsonvil		Anne		
	Funeral Director		214-70-3257	1 M 2 □ F		.9 Yrs.	Months Days		Min. Sept.	lav Year	Cour	lace (State or Foreign htry) SIANA
			Usual Residence of Decedent		·			J	дере.	17,1755	2041	
	how		10a. State 10b. County		10c.	City, Town or Lo	cation				1	0d. Inside City Limits
	Ba-1 s	cto	MD Anne A	runde1		Davi	dsonville	e				1 ☐ Yes 2 🛣 No
	or 2	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?
	e 23a	Funeral Director	2910 Conne Mar			110		1035	0.00 11 11	USA		
	ltem Item	nue	11. Marital Status 1 X Never Married 2 Marrie	Armed F	cedent Ever in Forces? : 2 1 No	0.5.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin an, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)	Blac	e - Ameno k, White,	an Indian, etc.
0000	irs aft	by F	3 Widowed 4 Divorced	If Yes, G	Sive		1 ☐ Yes 2X No	Specify:		Specify	Whi	te
5	2 hou		15. Decedent	s Education		16a. Deced	dent's Usual Occup	ation		16b. Kind of Bu	usiness/Ind	dustry
<u>'</u>	thin 7	ple	(Specify only highest Elementary/Secondary (0-12)		(1-4or 5+)	life.	kind of work done DO NOT use retired	during most of d)	working			
7	ed wil	Completed	12		,		none			no		
yland	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, L						Name (First, Middl		10)	
<u> </u>	ould Men varke	ပ	Gerald E. McCu						Janet Bru			
M	12 sh h and 7 ts m traum		19a. Informant's Name/Relationsh		. l		-		r Rural Route Num			
ອ໌ ອ໌	1 and Healt em 2 ther		Ann J. McCullo	ugn / mo		. Place of Dispo	sition (Name of		Davidsor Date	20c. Location -		
0	ages nt of t: If it		1 ABurial 2 Cremation		n State	cemetery, crer	natory or other plac		5/18/2005		•	
Daltimo	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatile and Mental Hygiene. Important: If them 27 is marked other than "natural", or teme 28a or 28a-f show any injury or other traumatic event, it a Medical Eracifier mast be notified at once.		* 4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L		A A		Name and Addre		Beall Fur			е, пр.
Ď	Dep Imp any		- CRin	- to.	الألع		512 NW C			e, Mb. 20		
	No.		23a. Part1. Enter the disease, or a shock, or heart failure. List of	complications that	caused the de				*			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	iny one days on	Λ.							Onset and Death HU years
	/Medical		resulting in death)	aDue to	o (or as a cons	equence of):	23					10 years
	Examiner		Sequentially list conditions,	b								
	D ii	Examiner	if any, leading to immediate cause. Enter Undertying	Due to	o (or as a cons	equence of):						
	and I-tran	хап	that initiated events resulting in death) Last	c. Due to	o (or as a cons	equence of):					-	
8/0C,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	aiE			(
	ficate g phys	edicai		d						,		
×	nding use a	W/u	IF FEMALE: 23b. Was decedent pregnant		utcome of preg		e and and an			23d. Dat	e of delive	нгу
Ď	death e atte	icia	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	4□Pre	birth 2∏Fe gnant at time o		Ectopic pregnancy Other (specify) _			Мо	nth	Day Year
5	at the by th stache	Physician/M	9 🗆 Unknown	9□ Unk	nown							
'n	The law requires that the death certif site has been signed by the attending bage 2 should be detached for use a	by F	Part II. Other significant condition	ns contributing to	death but not r	esulting in the u	nderlying cause giv	en in Part I.		•		ne cause of death?
coras	een s nould	ted							- 1	Yes 202No	3 L Prob	ably 4 Unknown
ပ်	2 2 2	Completed								opsy	prior to con	psy findings available apletion of cause of
		Co							1 ☐ Yes		death?	2 No
VILA	ician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:			Oth	or	Death (Check only			
5	Phys rthis ral dii	- To	1 Yes 2 No	1		ER/Outpatien 28b. Time of	I 3 DOA	4 🗀 Nursir	ng Home 5 Res	how injury occurr		/)
0	iding Ph th. After th funeral	tion	1 Natural 5 Pending 2 Accident investig		e of Injury onth, Day Year)	Injury	Wor	k? Yes 2□No	200. 2000.			
Vision	r Attencer death	ertification;	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Plac	e of Injury - At	home, farm, str	eet, factory, office			(Street and Numb	er or Rura	I Route Number,
5	safte	Cert	4 Homicide	buil	ding, etc. (Spe	city)			City of 10	own, State)		
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funerel Director: After this certifica completely filled in by the funeral director,	edical (29a. Certifier 1 Certifying	Physician: To the	ne best of my k	nowledge, death	occurred at the tir	ne, date and p	place, and due to the	cause(s) and ma	nner as st	ated.
	the H hin 24 the F nplete	Medi	one)	and ma	nner stated.	TOTAL CONTROL OF THE						
	o d with	<	29b. Signature and title of certifier	. 1	, ^		29c. Licens	e unwoet		29d. Date signed	a (Month, I	200
		9	17mg/	11/	MI		W 3.	78-18		May	,,0	, 2003
_	(1)		30. Name and address of person v	who completed car	use of death (It	em 23a) (Туре,	10 - C	enco	the G	Dag 0 1	4 m	121054
	Sta	te	31. Date filed (Month, Day, Year)	2000	Registrar's Sig	nature	د رسد. ي			-mor II	1 //	
	Registr		MAY 1 7 20	105	in A	1 6000	le le					

Dominic Natinaro

			Please	Type or Pri	nt in Black	Indelible In	k. Ensure A	II Copies	Are Legible.	
		For State Registrar			aryland / De		Health and M	fental Hyg		18170
Physicia /Medic Examin	al	1. Decedent's Name DOMENIC 4a. Facility Name (If r.	GEORGE	MARINA	RO	4b City Town	or Location of Death	2. Date of Dea Month MAY 12	ath Day Year	3. Time of Death 8:59 PM M
	-1	CIVISTA No. Social Security Nur	MEDICAL (CENTER	e (In yrs. last birtho	LAPLAT	ГА	8 Date of Birth	CHARLES	
Funeral Director		579-52-78 Usual Residence of D	356 ¹¹	M 2□F	64 Yr	Months Day		8. Date of Birtl (Month, Day MAY 20	, Year) Co	thplace (State or Foreign cuntry) ANDRIA, EGYP
Maryland	tor		10b. County		10c. City, Town of					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
h with the 23a or 284 st be not	Funeral Director	10e. Street and Numb	oer .	RT	, incomes via	10f. Zip Code 2063			U. S. A	
Jrs a	Š	11. Marital Status 1 Never Married 3 Widowed 4		12. Was Decedent Armed Forces? 17 Yes 2 1 If Yes, Give Year or Dates:	No	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Sp Iban, Mexican, Puerto o <i>Specify</i> :	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	erican Indian,
i within 72 ho iene. r than "natur I're Medical	Completed		5. Decedent's Ed y only highest grad dary (0-12)		5+)	ecedent's Usual Occ Give kind of work don fe. DO NOT use retii NAGER	e during most of work	ing	16b. Kind of Business	Industry
should be filed and Mental Hyg s marked other umatic event,	To Be C	17. Father's Name (Fi	NO MARINA	ARO			INES CA	RICATO	Maiden Surname)	
s 1 and 2 sh I Health and Item 27 is rr other traum		19a. Informant's Nam ELIZABETH 20a. Method of Dispo	A. MAR		FE 712	4 LANGLEY isposition (Name of	COURT HUGI	HESVILLE	r, City or Town, State, 2 MARYLAND 20c. Location - City or	20637
permit. Pages Department of i Important; if it any injury or o		1 ZBurial 2 D 4 Donation 5	Other (Specify		RESURR	ECTION CEM 22. Name and Add	IETERY 17	, 2005 C	CLINTON, MA ECHOLS FUN	L.HME.,P.A.
		23a. Part1. Enter the shock, or heart Immediate Cause (Fi	failure. List only o	dications that caused one cause on each time	M00641 I the death. Do not		XEE NOTCH I		CLOTTE HALL rest,	Approximate Interval Between Onset and Death
Physician /Medical Examiner		disease or condition resulting in death)	ſ	aDue to (or as	a consequence of)	any	UNOC.			
secuted and and I-transit	aminer	Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or in that initiated events	jury	b. Due to (or as	a consequence of)	:				
6 ⊂ .03	ũ	resulting in death) La	st	Due to (or as	a consequence of)					
The faw requires that the death certificate be use has been signed by the attending physicia cage 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent p in the past 12 m 1 Yes 2 T 9 Unknown	onths?	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death	3 Dectopic pregnan 5 Other (specify)	су		23d. Date of del Month	ivery Day Year
w requires tha been signed I should be det	2	Part II. Other significa	ant conditions co	entributing to death be	ut not resulting in th	e underlying cause g	Iven in Part I.		bacco use contribute lo es 2☑No 3□Pr	the cause of death?
	Completed							24a. Whas a autops perform	med // death?	topsy findings available completion of cause of
iysician: The	ro Be	25. Was case referred examiner? 1 \(\text{Yes} = 2 \)		Hospital: 1 ☐ Inpatie	ont 2□ER/Outpa	itient 3 DOA O	26. Place of Death ther: 4 \(\subseteq \text{ Nursing Ho.} \)		ence 6 □Other (Spec	cify)

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physic within 24 hours after death.

To the Funeral Director: After this concepts of completely filled in by the funeral director.

Medical Certification; To I

27. Manner of Death 1 Natural

2 Accident

3 Suicide

4 - Homicide

29b. Signature and title of certifier

29a. Certifier (Check only one) 5 Pending

investigation

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MTCHAEL A LEATHERWOOD MD 12070 OLD LTNE

28a. Date of Injury (Month, Day Year)

MICHAEL A LEATHERWOOD MD 12070 OLD LINE CENTER SUITE 202 & 210 WALDORF MD 20602
31. Date filed (Month, Day, Year) | 32. Registrar's Signature

MAY 1 6 2005

Registrar's Signature

Medium & Spark

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D-21031

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

/Media	an i	Decedent's Name (F MARY	JUNE		,	M A TIME TAKE	v			Date of Dea Month	Day	Year	
Examir		4a. Facility Name (If no		e street and number)		MATTINGI 4b. Cit	y, Town, or I	Location of D		MAY	12 4c. Cour	200 nty of De	
Lxamii	iei	25932 SHE				ME	CHANI	CSVILI	Æ		ST.	. MAI	RY 'S
uneral		5. Social Security Numl		ex 7. Ag	e (In yrs. last I	Yrs. If Unc		If Under 24 Hours	Hrs. 8. Min.	Date of Birtl (Month, Day	h /, Year)	9. Bi	irthplace (State or Fore Country)
irector		214-36-474 Usual Residence of De			65	115.			MA	Y 15,	1939	MAR	RYLAND
how		10a. State 10	Ob. County	L. MARY'S		wn or Location	017TT T T	,					10d. Inside City Limi
Ba-f s	Director			. MAKI S	F	TECHANIC		<u>'</u>					1 ☐ Yes 2 X 1
a or 2	o ii	10e. Street and Number 25932 SHEN		DDTVE		1	Zip Code 20659				10g. Citizen d		Country?
nial rygiene. ed other then "naturel", or liems 23s or 28s-1 show event, the Medical Examinar must be notified at	Funeral	11. Marital Status	MANDOAII	12. Was Decedent		13. Was Dec	edent of His	panic Origin	? (Specify	Yes or No-	U.S		nerican Indian,
or Iter		1 Never Married		Armed Forces? 1 ☐ Yes 2 🛣 If Yes, Give		If Yes, sp	ecify Cuban	, Mexican, F Specify:	Puerto Rica	an, etc.)	В	Black, Wh	
urel',	d by	3 XWidowed 4		Year or Dates:							Spec		WHITE
"nat	Completed	(Specify	only highest gra	de completed)		ia. Decedent's Us (Give kind of v life. DO NOT	vork done du	ırina most ol	f working		16b. Kind of INTERN		,
al Hyglene. I other then '	шо	Elementary/Seconda	ary (0-12)	College (1-4or		MINISTR	ATIVE	CLERK					UNION
al Hyg	Bec	17. Father's Name (First						18. Mother's	Name (Fi	rst, Middle,	Maiden Sum	name)	
ng Mental marked o imatic eve	2	FREDDY H									VANWA		
27 Is m r traum		19a. Informant's Name DANIEL W.				9b. Mailing Addre 35985 ARI							Zip Code) MD 20659
tem othe		20a. Method of Disposi			20b. Place	of Disposition (N	ame of		Date	-			r Town, State
nent or int: If its iry or o		1 X Burial 2 □ C ` 4 □ Donation 5 [Removal from State		tery, crematory of D HEART	r other place,	MA	Y 16,	2005	BUSHW	00D,	MARYLAND
Department of Important: If i eny injury or one	li	21. Signature of Funer			_		and Address	of Facility	BRINS	FIELD	-ЕСНОІ	LS FU	JNL.HME.,P.
3 5 5 5		Your	1850	- John		30195	THREE	E NOTC	H RD.	CHAR	LOTTE	HALL	, MD 20622
aminer	le.	Conversionly lies condition	tions,	b. Corona	a consequenc		ase						J
sician and burial-transit	ai Examiner	Sequentially list condit ouse. Enter Underlyin Cause (Disease or inju- that initiated events resulting in death) Last	ng Iry	c. Diabet	tes Mel	litus							
by the attending phy. iached for use as the	edicai	IF FEMALE: 23b. Was decedent proin the past 12 mo 1 Yes 2 Number 1 Yes 2 Number 2 Nu	egnant parts?	c. Diabet Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	a consequence of pregnancy 2 Fetal death time of death	litus e of): th 3□Ectopic 5□ Other (pregnancy specify)				4	Date of de Month	Day Year
igned by the attending phy. be detached for use as the	by Physician/Medicai	Cause. Enter Underlyin Cause (Disease or injuthat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent print in the past 12 mo	egnant parts?	c. Diabet Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	a consequence of pregnancy 2 Fetal death time of death	litus e of): th 3□Ectopic 5□ Other (pregnancy specify)	n in Part I.			bacco use co	Month ontribute	Day Year to the cause of death?
been signed by the attending phy. should be detached for use as the	by Physician/Medicai	IF FEMALE: 23b. Was decedent proint in the past 12 mo 1 Yes 2 N 9 Unknown Part II. Other significant	egnant paths?	c. Diabet Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	a consequence of pregnancy 2 Fetal death time of death	litus e of): th 3□Ectopic 5□ Other (pregnancy specify)	n in Part I.		1 🗆 Y	bacco use co	Month ontribute	Day Year to the cause of death? Probably 4 ⊟Unknow
has been signed by the attending phy. je 2 should be detached for use as the	by Physician/Medicai	IF FEMALE: 23b. Was decedent proint in the past 12 mo 1 Yes 2 N 9 Unknown Part II. Other significant	egnant paths?	c. Diabet Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	a consequence of pregnancy 2 Fetal death time of death	litus e of): th 3□Ectopic 5□ Other (pregnancy specify)	n in Part I.		1 TY 24a. Was a autop: perfor	bacco use co	ontribute of a prior to death?	Day Year to the cause of death? Probably 4
ate has been signed by the attending phy page 2 should be detached for use as the	e Completed by Physician/Medical	IF FEMALE: 23b. Was decedent proin the past 12 mo 1 Yes 2 N 9 Unknown Part II. Other significant	egnant phis?	c. Diabet Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	a consequence of pregnancy 2 Fetal death time of death	litus e of): th 3□Ectopic 5□ Other (pregnancy specify) cause giver	n in Part I.	Death (C)	1 Yas a autop perfor	bacco use co	ontribute of a prior to	Day Year to the cause of death? Probably 4
is certificate has been signed by the attending phy director, page 2 should be detached for use as the	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent print the past 12 months of	egnant others?	c. Diabet Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	of pregnancy 2 Fetal death time of death but not resulting	litus e of): th 3□Ectopic 5□ Other (pregnancy specify)	26. Place of		1 Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y	bacco use co	ontribute 3 F b. Were a prior to death? 1 Ye	Day Year to the cause of death? Probably 4 ⊞thknor autopsy findings availa o completion of cause of
this certificate has been signed by the attending phy al director, page 2 should be detached for use as the	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent proint the past 12 mo 1 mo 1 mo 1 mo 1 mo 1 mo 1 mo 1 m	egnant phis? o	c. Diabet Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown ontributing to death b ATTICAL Hospital: 1 Inpatie 28a. Date of Inju (Month, Da	of pregnancy 2 Fetal death time of death time of death 2 ERVCurv 28b	1itus e of): 1itus e of): th 3 Ectopic 5 Other (pregnancy specify) I cause giver OOA Other 28c. Injury a	26. Place of 4 Nursia	ng H <i>o</i> me 28d.	1 Yas a autop: perfor 1 Yes	ibacco use co les 2 No les 2 No les 2 No les 24t sy med? 2 No	Month ontribute 3 F b. Were a prior to death? 1 Ye	Day Year to the cause of death? Probably 4 Hothknov autopsy findings availal of completion of cause of
i, Her this certificate has been signed by the attending phy funeral director, page 2 should be detached for use as the	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent proint the past 12 months in the past	egnant parts? o nt conditions co	c. Diabet Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown ontributing to death b ATT TENT Hospital: 1 Inpatie 28a. Date of Inju (Month, Da	of pregnancy 2 Fetal death time of death out not resulting.	th 3 Ectopic 5 Other (pregnancy specify) cause giver cause giver cause giver 28c. Injury a Work? 1 □ Ye	26. Place of	ng H <i>o</i> me 28d.	1 Y Y 24a. Was a autop: perfor 1 Yes heck only or 5 Pescribe h	bacco use co	Month ontribute 3 F b. Were a prior to death? 1 Ye Other (Spi	Day Year to the cause of death? Probably 4 ⊕thknor autopsy findings availa completion of cause of s 2 □ No
i, Her this certificate has been signed by the attending phy funeral director, page 2 should be detached for use as the	ertification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent proint the past 12 months in the past	egnant phis? o	c. Diabet Due to (or as d. 23c. If yes, autcome 1 Live birth 4 Pregnant at 9 Unknown Ontributing to death b ARTECRY Hospital: 1 Inpatie 28a. Date of Inju (Month, Da	of pregnancy 2 Fetal death time of death out not resulting.	1itus e of): 1itus e of): th 3 Ectopic 5 Other (pregnancy specify) cause giver cause giver cause giver 28c. Injury a Work? 1 □ Ye	26. Place of 4 Nursia	ng H <i>o</i> me 28d.	1 Y Y 24a. Was a autop: perfor 1 Yes heck only or 5 Pescribe h	ibacco use codes 2 No les 2 No	Month ontribute 3 F b. Were a prior to death? 1 Ye Other (Spi	Day Year to the cause of death? Probably 4 Hothknov autopsy findings availal of completion of cause of the
i, Her this certificate has been signed by the attending phy funeral director, page 2 should be detached for use as the	edical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent print in the past 12 mo 1 Yes 2 No 2	egnant purs? ont conditions cond	c. Diabet Due to (or as d. 23c. If yes, autcome 1 Live birth 4 Pregnant at 9 Unknown Ontributing to death b ARTECRY Hospital: 1 Inpatie 28a. Date of Inju (Month, Da	of pregnancy 2 Fetal dea to time of death out not resulting the pour not resulting by Year) 28b (Specify) of my knowled of examination a	th 3 Ectopic 5 Other (pregnancy specify) cause giver cause giver 28c. Injury a Work? 1 — Ye ony, office	26. Place of 4 □ Nursinat at ps 2 □ No	28d.	1 Y Y 24a. Was a autop perfor 1 Yes heck only or 5 Preside Describe h	ibacco use codes 2 No no 24th symmed? 2 No no ence 6 Code ow injury occurrent and Nur n, State)	Month ontribute 3 F b. Were a prior to death? 1 Ye Other (Specurred	Day Year to the cause of death? Probably 4 Hothknov autopsy findings availat b completion of cause of as 2 No Rural Route Number, as stated.
i. Her this certificate has been signed by the attending phy funeral director, page 2 should be detached for use as the	dical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent proint the past 12 months in the past	egnant purs? ont conditions cond	c. Diabet Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown ontributing to death b ATCTCAY Hospital: 1 Inpatie 28a. Date of Inju (Month, Da	of pregnancy 2 Fetal dea to time of death out not resulting the pour not resulting by Year) 28b (Specify) of my knowled of examination a	th 3 Ectopic 5 Other (pregnancy specify) cause giver cause giver 28c. Injury a Work? 1 — Ye on, office	26. Place of 4 □ Nursine at es 2 □ No and and and and and and and an	28d. 28f. place, and occurred a	1 Y 24a. Was a autop: perfor the ck only or the ck	bacco use codes 2 No an 24t Symed? 22 No ane 6 Coow injury occurrent and Nur cause(s) and place	Month ontribute 3 F b. Were a prior to death? 1 Ye Other (Speurred	Day Year to the cause of death? Probably 4 Hothknov autopsy findings availat b completion of cause of as 2 No Rural Route Number, as stated.
i, Her this certificate has been signed by the attending phy funeral director, page 2 should be detached for use as the	edical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent proint the past 12 months in the past	egnant egnant phs? o to medical to medical could not be determined certifying Ph Medical Exam	c. Diabet Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown ontributing to death b ATCTCAY Hospital: 1 Inpatie 28a. Date of Inju (Month, Da	of pregnancy 2 Fetal dea to time of death out not resulting the pour not resulting by Year) 28b (Specify) of my knowled of examination a	th 3 Ectopic 5 Other (pregnancy specify) cause giver cause giver 28c. Injury a Work? 1 — Ye on, office	26. Place of 4 □ Nursinat es 2 □ No e, date and p nion, death of	28d. 28f. place, and occurred a	1 Y 24a. Was a autop: perfor the ck only or the ck	bacco use codes 2 No an 24t Symed? 22 No ane 6 Coow injury occurrent and Nur cause(s) and place	Month ontribute 3 F b. Were a prior to death? 1 Ye Other (Spi urred manner a e, and du ned (Mon	Day Year to the cause of death? Probably 4 Hothknov autopsy findings available completion of cause of the c

			1 - For State Registrar		Marylan	-	artment o			/lental Hyg	iene	05	18172
	Physici /Medic		1. Decedent's Name (First, Middle, La Rose Marie I							2. Date of Death Month May 16,	Day	Year	3. Time of Death 4:15 A ^M
	Examin		4a. Facility Name (If not institution, give 7902 Clover Hill		ber)			n, or Location	of Death			y of Death	1-
	Funeral		Social Security Number 6. 8	Sex 7	. Age (In yrs.	last birthday)	If Under 1 Ye	ear If Unde	r 24 Hrs.	8. Date of Birth			olace (State or Foreign
	Director		212-24-6754 Usual Residence of Decedent	□M X F	76	Yrs.	Months Da	ys Hours	Min.	Jan. 14,	1929	Mary	land
	ryland	_	10a. State 10b. County		10c. City	y, Town or Lo	cation					1	0d. Inside City Limits
	the Ma 28e-1 e	ecto	Maryland Frederic	k	Fr	ederic	10f. Zip Coo	10			Og. Citizen of	What Cour	1 Tyes XXNo
	h with	al Dir	7902 Clover Hill I	rive				 1702				ISA	my:
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28e-1 show eumatic event, the Medical Eventrement of the confilled.	by Funeral Directo	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Deced Armed For 1 Yes If Yes, Give Year or Da	ces? 2 No	1	Was Decedent f Yes, specify (pecify Yes or No- Rican, etc.)		ce - Americack, White,	
21215-0036	within 72 hor ane. Ihan "naturi e Medical	Completed	15. Decedent's E (Specify only highest gr.		4or 5+)	(Give	dent's Usual Ockind of work do NOT use re Waitre:	ne during mo tired)	st of work	ing	16b. Kind of E		^{dustry} Organization
Maryland 2	9 7 >	To Be Co	17. Father's Name (First, Middle, Last Edward	Smit	h			18. Moth		e (First, Middle, M	faiden Suma		
Mar)	d 2 sho h and I 7 le me treume		19a. Informant's Name/Relationship							al Route Number. Freder			
	es 1 and 2 should b of Health and Ment: fitem 27 le marked r other treumatic e		Linda S. Miller/Da 20a. Method of Disposition			lace of Dispo	sition (Name o	1		-	20c. Location		
altimore,	Page Iment c tant: If jury or		1 Burial 2 Cremation 3 Control of the Control o	(y)	tate	ion Cha	pel Cer	netery	5/19	/2005	Libert		
Ball	permit. Pages : Department of It Important: If ite any injury or ot once.		21. Signature of Funeral Service Lice	Var		16	21 Оро	ssumtov	m Pi	auffer F ke, Fred	lerick,		21702
	American and was control of the buriar-transit the	Examiner	23a. Part1. Entè-the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	or as a consequent as a consequent	uence of):	W	dyling, addit as	Scarolac	or respiratory arre	rat,		Approximate Interval Between Onset and Death
O. Box 68760,	ath certifii ittending p or use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		th 2 ☐ Fetal ntat time of de	Ideath 3	Ectopic pregna Other (specify		·,			ate of delive	ery Day Year
۵.	quires that the de in signed by the a uld be detached f	by	Part II. Other significent conditions	contributing to dea	ath but not resi	ulting in the u	nderlying cause	given in Part	l.		acco use cor s 2 🗆 No	atribute to th	ne cause of death?
al Records,		Completed	311/3							24a. Was ar autopsy perform 1 Yes 2	/	prior to con death?	psy findings available mpletion of cause of 2 No
Division of Vital	A 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1											y)	
Divis	tel or Attenders after deathal Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	200. Flace	of Injury - At ho g, etc. <i>(Specif</i>)	ome, farm, str	eet, factory, off	се		28f. Location (Str City or Town	eet and Num , State)	ber or Rura	d Route Number,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	(Check only 2 Medicel Exer	nysician: To the I miner: On the ba and mann	sis of examina	wledge, death tion and/or inv	estigation, in n	e time, date any opinion, des	nd place, ath occur		use(s) and mate and place,	and due to	the cause(s)
	To To		29b. Signature and title of certifier	PIN 11-			230, 1,10	22	101	25	Me 1	17)	(L (
	9		30. Name and address of person who	completed cause	of death (Item	23a) (Type,	Print) 7	ame	al	1 ha	A	10	rel 2/14
	Sta Registr		31. Date filed (Month, Day Year)	2005 ^{32. R}	ejstrar's Signa	иле	Santi s			6	a an		17

			1 - For State Registrar	State of Ma	aryland		artmen			and M		iene _{og. No.}	05	18173
	Physicia	an	Decedent's Name (First, Middle, Last))							2. Date of Dear Month	th Day	Year	3. Time of Death
	/Medic		Chester L. Mo								May	15	2005	4:10 A M
	Examin	er	4a. Facility Name (If not institution, give					_	Location of	of Death			nty of Death	
			2304 Mt Ephraim Ro		e (in yrs. lasi	t hirthday)	A o	lams	town If Under:	24 Hrs	B. Data of Birth		derick	
	Funeral Director			X 7. Ag	61	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day) Aug. 4,	Year)	Kent	lace (State or Foreign atry)
			Usuel Residence of Decedent		01						Aug. 4,	1945	Kenc	иску
	yland		10a. State 10b. County		10c. City, T	Town or Lo	cation						1	0d. Inside City Limits
	• Mar	ctor	Maryland Frederi	ck		Adar	nstown	n						1 ☐ Yes 2 ☑ No
	th the)ire	10e. Street and Number				10f. Zip	Code			1	0g. Citizen o	of What Cour	ntry?
	23a	Funeral Directo	2304 Mt. Ephraim	Road				2	1710	_		Un	ited S	tates
	r dea	ne	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Deced f Yes, spec	ent of His	spanic Origin, Mexican	gin? (Spe	cify Yes or No- Rican, etc.)		lace - Americ lack, White,	
36	s afte or li	by Fi	1 Never Married 2 Married	1 ⊠Yes 2 □ I If Yes, Give			1 ☐ Yes 2		Specify:			Spe	cify: Wh	ite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28e-f show h. Wedical Examer must be motified at	q pe	3 Widowed 4 Divorced	Year or Dates:			dent's Usua	LOccupa	tion			16h Kind of	Business/Inc	duce
7	in 72	olete	15. Decedent's Edu (Specify only highest grad	e completed)		(Give	kind of wor DO NOT us	k done d	luring most	t of worki	ng			
7	with iene. thar	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Sig	gnal S	Cechi	nicia	n		Wash Gove	ington rnment	i, DC
D	filed I Hyg othe	Bec	17. Father's Name (First, Middle, Last)				J				(First, Middle, I			
<u>lar</u>	Ald be Alenta rked tic ev	To B	Chester Louis Mo	rris					Ma	ry J	ane Cole	eman		
Maryland	sho and h		19a. Informant's Name/Relationship (Ty	rpe, Print)		19b. Mailir	ng Address	(Street a	and Numbe	r or Rura	Route Number	; City or Tou	m, State, Zip	Code)
	s 1 and 2 of Health ar item 27 Is other treu		Veda Darlene Morr	is / Wife			4.4		aim R		Adamsto		•	
ore	of H of H if iten		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ F	Removal from State	20b. Plac	e of Dispo etery, crer	sition (Nan natory or ol	ne of ther place	9)			20c. Locatio	n - City or To	wn, State
Ē	Pag tment tant: jury o		* 4 ☐ Donation 5 ☐ Other (Specify)		Rest		n Mem				18,	reder	ick, M	laryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than *natural', or items 23a or 28e-f show any injury or other treumatic event, it. Medical Examera must be maifted at one.		21. Signature of Funeral Service Licens	A		16	Name and $21~\mathrm{Op}$	ossu	s of Facilit IMTOW	y Sta n Pil	uffer Fu ke Fred	ineral lerick	Homes , Mary	, P.A. land 21702
г			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused ne cause on each li	the death. I	Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between
	Pnysician	W 1	Immediate Cause (Final disease or condition	CHRON	ic ()BS-	TRUCT	いど	JUCK	חשפת	ny D	isen &	t	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequen	nce of):	_		U					
	Lamino	<u>_</u>	Sequentially list conditions.	Due to (or as	URE		THR	06_	4					
	ted sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1	a consequen		Con	Ot a	m	00-	Tus			
	axecur al-trar	Examiner	that initiated events resulting in death) Last	Due to (or as		nce of):			1	3 [11	''/			
8760,	death certificate be executed e attending physician and id for use as the burial-transit	caiE		1										
9	tificat ng phy as the	edi												
Вох	eath certif attending for use as	M/U	230. Was decedent pregnant	3c. If yes, outcome 1⊟Live birth			Ectopic pre	anancy					Date of delive	*
		Physician/Medical	in the past 12 months? 1 Yes 2 No	4☐Pregnant at			Other (spe					,	Month	Day Year
P.O.	The law requires that the ste has been signed by the bage 2 should be detache	Phy	9 Unknown								00 - Bids-1			
	w requires that been signed I should be det	by	Part II. Other significant conditions con	ntributing to death b	ut not resultir	ng in the ui	nderlying ca	use give	n in Part I.			oacco use co es 2 □ No		ably 4 Monknown
orc	requi	sted				-					1016	2 140	0 0 7 100	ably 4 GOTIATIONT
Sec	e law has b	Completed									24a. Was a autops perform	y	b. Were autoperior to condeath?	osy findings available apletion of cause of
al F											1 Yes 2	No	1 ☐ Yes	22 No
<u> </u>	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:				A Othe	-		(Check only on			
of		To	1 ☐ Yes 2 Ø No	1 Inpatie		VOutpatien 3b. Time of		^	4 🗆 140	_	ne 5 Reside			7)
OU	tending Physicien: leath. tor: After this certific the funeral director.	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year)	Injury	М	Bc. Injury Work 1	? ′es 2 □ l					
Division of Vital Records,	or Attending after death. Director: After in by the fune	ifica	3 Suicide 6 Could not be	28e. Place of Inj	ury : At home	e, farm, str	eet, factory	, office		2	8f. Location (St	reet and Nur	mber or Rura	I Route Number,
á	Dir	Certification:	4 Homicide	building, et	c. (Specity)						City or Town	i, State)		
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical (29a. Certifier 1 Certifying Physical Check only one)	sician: To the best ner: On the basis o and manner st	f examination	edge, death n and/or inv	occurred a vestigation,	at the tim- in my op	e, date and inion, deal	d place, a	and due to the ca	use(s) and i ate and place	manner as st e, and due to	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier				29c	License	number		2	9d. Date sign	ned (Month, i	Day, Year)
)	5		15/42				D	06	1795	5 1		05 -	16.	2005
	Q		30. Name and address of person who co		leath (Item 23	3a) (Type,	Print) L Hou	se-	Ave	Fn	theruu		0 21	
	Sta Registr		31. Date filed (Month, Day, Year)	-	ar's Signature		bart	1						
				0.10	A-1-1-1		7							

		_ 1	FOR	artment of Health and Mer	ntal Hygier Reg. I	4000 101/4
	Obveisie		1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year 3. Time of Death
	Physicia /Medic	al	Cheryl L. Carpel Moon	4b. City, Town, or Location of Death	lay 14,	2005 2:10A [™] 4c. County of Death
	Examin	er	4a. Facility Name (If not institution, give street and number) 7210 E. Sundown Ct.	Frederick		Frederick
4,	Funeral Director		5. Social Security Number 218-54-6778 6. Sex 1 M 2 F 55 Yrs.	y If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min. J	Date of Birth (Month, Day, Yea UIY 12	9. Birthplace (State or Foreign County) 1949 C.
	pue »		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation		10d. Inside City Limits
	Maryli f aho	to	MD Frederick	Frederick		1 X Yes 2 □ No
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f ahow other traumatic event, the Wadical Examinational be mailified at	Funeral Director	10e. Street and Number 7210 E. Sundown Ct.	10f. Zip Code 21702	10g.	Citizen of What Country? USA
(C)	of items 2	Funer	1 Never Married 2Ft Married 1 ☐ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rican)	Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
903	iral', o	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		405	. Kind of Business/Industry
21215-0036	n 72 h	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	160	, Kind of Business/Industry
212	d withing in the M	omo		omemaker		own home
Maryland 2	S should be filed withing and Mental Hygiene. In marked other than aumatic event, the Mental Hygiene.	To Be C	17. Father's Name (First, Middle, Last) Stanley Lapkoff	18. Mother's Name (F		den Sumame)
Mary	and 2 should I ealth and Men n 27 Is marks ner traumatic		19a. Informant's Name/Relationship (Type, Print) Frank Moon (Husband) 721	ling Address (Street and Number or Rural R 0 E. Sundown Ct.,	oute Number, Cit Frede	ty or Town, State, Zip Code) rick, MD 21702
Baltimore,	9 = 9		20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	position (Name of ematory or other place) 5/16940 ven Memorial Gardn		. Location - City or Town, State rederick, MD
Baltir	permit. Pa Departmer Important any injury once.		T E Bollius (op 1)	Bonald B. Thompso 31 E. Main St., M		ral Home own, MD 21769
	×		23a. Fig. Enter the disease, or complications that caused the death. Do not e shock, or heaft failure. List only one cause in each line.			
7	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	1cz espera	die	
		Iner	Sequentially list conditions, any issuing to immediate cause. Enter Underlying Cause (Disease or injury	7-6:90-7		6 2
,092	be executed ician and burial-transi	i Examiner	Cause Disease of injury that initiated events c. resulting in death) Last Due to (or as a consequence of):			
6876	cate b physic the b	dicai	d			
.O. Box 6	ne death certificate be executed the attending physician and shed for use as the burial-transit	by Physician/Med		B ⊟Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
a	requires that the deen signed by the hould be detached	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
Records,	e law has b je 2 sl	Completed			24a. Was an autopsy performed	
Vital	ician: Th certificate rector, pag	e Co	25. Was case referred to medical	26. Place of Death (1□Yes 2 Check on one	10 10 10 20 100
>		0 8	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	ent 3 DOA Other: 4 Nursing Home	5 Flesidence	e 6 □Other (Specify)
Division of	fter fter	ation: T	27. Manner of Death 1		d. Pescribe how i	injury occurred
Divisi	I or Attendi after death. Director: A I in by the fu	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f	f. Location (Stree City or Town, S	t and Number or Rural Route Number, Itate)
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Medical C	29a. Certifier (Check only one) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de admination and/or and manner stated.	ath occurred at the time, date and place, and investigation, in my opinion, death occurred	d due to the caus at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	1		Ed in) DI4C 3C	u	129 15,2005
	4		30. Name and address of person who completed cause of death (Item 23a) (Type	pe, Print)	c. /	ang 15,2005
Ş	St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Recistrar's Signature MAY 1 7 2005	Acorts.		

TOUR ALTON

0

			State of Maryland / Dep	artment of Health and Mertificate of Death		005 18175					
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death						
	Physicia		Carl Verdean McGowan		May	Day Year 1/30 AM					
	/Medic Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death					
			Washington County Hospital	Hagerstown		Washington					
	Funeral Director		5. Social Security Number 220-30-9723 6. Sex 1⊠ M 2□ F 71 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y July 21	9. Birthplace (State or Foreign Country) Maryland					
	pu .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits					
	Aaryle I sho	ច		rstown		1⊠Yes 2 No					
	286-	Director	10e. Street and Number	10f. Zip Code	100	J. Citizen of What Country?					
	h with		437 Jefferson Street	21740		USA					
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.					
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Importent: If item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other traumatic event, it is Madical Evant and interest conflict any once.	b	1 ☐ Never Married 2 ☐ Married 1XIYes 2 ☐ No II Yes, Give Year or Dates: 1952-55	1 ☐ Yes 2 ☑ No Specify:		Specify: white					
21215-0036	72 hou	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work	ing 16	6b. Kind of Business/Industry					
121	within ane. than "	du	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) quipment operator	c	city government					
d 2	filed Hygie other ent, II	Be Co	17. Father's Name (First, Middle, Last)	<u> </u>	e (First, Middle, Ma	, 0					
Maryland	uld be Mental irkad tic ev	To B	Lawrence W. McGowan	R. Mea	rl Godlov	7e					
lary	2 short			ling Address (Street and Number or Run							
<u>გ</u>	l and lealth im 27 her tr			Jefferson St., Ha		Dc. Location - City or Town, State					
Baltimore,	ages ant of H it: If ite y or of			ematory or other place)		Hagerstown, Maryland					
altir	mit. P partme sorten y injur				45.	FUNERAL HOME					
<u> </u>	e e e			415 E. Wilson Blvd							
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arres	Approximate Interval Between Onset and Death					
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due 16 for as a consequence of):								
	Examiner										
		Jer	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury								
	ocuted nd transit	Examiner	that initiated events C.								
8760,	death certificate be executed e attending physician and bd for use as the burial-transit	al Ex	resulting in death) Last Due to (or as a consequence of):								
687	ficate physis the	edlcal	d								
Вох	leath certific attending p	In/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	☐Ectopic pregnancy		23d. Date of delivery					
	ne deat the att	Physician/Me		Other (specify)		Month Day Year					
P.O.	that the de ed by the detached	Ph	Part II. Other significant conditions contributing to death but net resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?					
rds,	as gn	d by	Colonic lym	hamor.	1 🗆 Yes	2 0 3 Probably 4 Unknown					
Records	- L 0	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of					
E E	The te h	mo:			perform						
ita	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	The second secon	th (Check only one						
of Vital	Physician: this certific	은	1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient 2 ☐ ER/Outpati		ome 5 Residen	ce 6 Other (Specify)					
ou c	Jing After fune	tlon	27. Manner of Death 1. Matural 5 □ Pending 2 □ Accident investigation 2 □ Accident investigation 2 □ Accident investigation		Zod. Describe nov	Villary occurred					
Division	or Attending after death. Director: After d in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s	street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number,					
Ö	in Cite	Cert	4 ☐ Homicide building, etc. (Specify)		City of Town,	State)					
	To the Hospital or Attend within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) Check one) Check only one) Check only one) Check								
	To the vithin 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month, Dey, Year)					
)			Mud Hamdon	nD D4647	5 1	May 16, 2005					
<i>i.</i> 1	ا . ، سب		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)	C T	- Haran town					
TI -	5+1 Sta	ate	31. Date filed (Month, Day, Year) Fundament 2005	1120 014		2172 A					
	Regist		MAY 17 2005 See S. s	Sperke		V					

		1-	For State Registrar				d / Depa	artment of the tificate of	Health a		ental Hy	_	05	18176
Phys	iolar		Decedent's Name (First, Middle								2. Date of De	ath	Year	3. Time of Death
/Me	dica		Fecility Name (If not institution,	Herman		ERS		4b. City, Town,	or Location of		May 12		ty of Death	1240рм
Exan	nine		3105 Glenmore					•	hesda	Death			tgome	
Funer Directe		04	9-01-6931	6.Sex 17∑M 2[e (In yrs. I. 87	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da Feb. 9	, 1918	9. Birth	place (State or Foreign intry) necticut
rland ow			L. State 10b. County			10c. City	, Town or Lo	cation						10d. Inside City Limits
e Many	1	Ma	aryland Montgo	omery		Ве	ethesd	a						1 ☐ Yes 2 ☑ No
with the a or 26	2	100	s. Street and Number 3105 Glenmore	Spring	Road			10f. Žip Code	20817			10g. Citizen o		•
death ms 23	0	11.	Marital Status	12. Wa	s Decedent ned Forces?	Ever in U.	S. 13.	Was Decedent of I f Yes, specify Cub	Hispanic Orig	jin? (Spec	offy Yes or No	- 14. R		ican Indian,
DERITINOTE; INIGITY IGHTIO Z. I.Z. 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show say jollury or other traumatic event. The Medical Event and the notified at	- Constant	6	1 Never Married 2 Marri 3 Widowed 4 Divorced	ed 1 If Y	Yes 20 1 es, Give A ar or Dates:	Мо		1 ☐ Yes 2 No		, Fuello A	iican, etc.)		ack, White ify: whi	
ithin 72 h ne. "natu Medical	0	Della E	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t grade comp	llege (1,4or 5	i+)	(Give life. i	dent's Usual Occu kind of work done DO NOT use retire	pation during most ed)	of workin	g	16b. Kind of		
filed w Hygier ther th	3	17.	Father's Name (First, Middle, I	<u> </u>			EC	OHOMISC	18. Mother	r's Name	(First, Middle,	, Maiden Suma		
rid be file Mental Hy riked oth	900	5	Louis Myers	,					Ве	11a	Squire			
WICH Y	I.	198	a. Informant's Name/Relationsh	ip (Type, Pri	nt)			g Address (Stree						
Health Health Hem 27			va Myers, Wife			20b. P		Glenmor sition (Name of natory or other pla			oad, B	etnesda 20c. Location	•	20817 Town, State
Pages nent of int: If if	de		1 ঐBurial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		I from State	Jude	ean Me	morial G	ardens	0.5/	13/05	Olney	, MD	
Dallinore, Dermit. Pages 1 a Department of Hez mportant: If item iny injury or othe	ouce.	21.	Signature of Funeral Service I	icensee	Do			orchinsk	the state of the s				(10,143)	
005%	a	23	a. Part1. Enter the dise so, or shock, or heart failure. List	complications	that caused	the death		54 Carro					DC	20012 Approximate
Physicia /Medic Examin	al	lmı dis	shock, or heart failtyfe. List mediate Cause (Final lease or condition sulting in death)	a	se on each li	Tyl	uple	oma						Interval Between Onset and Death
OX OS/OU, certificate be executed rding physician and use as the burial-transit		Sec if a cau cau tha res	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Disease or injury that intitated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											
ate be ex hysician the buria	100	2		d										
death e atter			FEMALE: b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 4	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)								ate of delivery Ionth Day Year	
ords, F.C requires that the een signed by the hould be detached.	0	2 2	t II. Other significant condition	ns contributir	contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? 1 Yes 2 PNo 3 Probably 4 Unknown				
The law requires the has been sign bage 2 should be			a							Was an 24b. Were autopsy findings available prior to completion of cause of death?				
		25.								1 🗆 Yes	2 No			
- S S	1.6)	examiner? 1 ☐ Yes 2 🗹 No	Hospita	l: 1 □ Inpatie	ent 2	ER/Outpatier	it 3□ DOA Ot				dence 6 🗆 O	ther (Spec	ify)
ION O) Inding Ph ath. r: After th		27.	Manner of Death 1 Natural 5 Pendin 2 Accident investig	9	. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury	Wo	iryat ork?]Yes 2 □ N		8d. Describe	how injury occi	urred	
DIVISION all or Attending s after death. all Director: Afte		28a. Date of Injury 1 P Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Section of Death 1 properties 28c. Injury at Work? 1 properties 28c. Injury at Work? 1 properties 28c. Injury at Work? 28c. Injury at University and Section of Section							ral Route Number,					
UNISION O To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral			a. Certifier 1 Certifyin (Check only 2 Medical one)	Examiner: Or	To the best n the basis o id manner st	f examinal	wledge, deatl lion and/or in	n occurred at the t vestigation, in my	ime, date and opinion, deat	d place, as th occurre	nd due to the d at the time,	cause(s) and r date and place	nanner as , and due	stated. to the cause(s)
To the comp			b. Signature and title of certifier		11	4			se number	06	6	29d. Date sign	ed (Month	, Day, Year)
4		30	Name and address of person		ad cause of	leath (Item	23a) (Type		024	U	4		~/	03
-7		I	Eva L. Myers,	M.D.,	4300 M	lontgo	omery	Ave., #1	01, Be	thes	da, MD	20814		
	State istra	31.	Date filed (Month, Day, Year)	3 2005	32. Figistr	ar's Signa	b A	parle						

			. For	State of Mary	land / Depa	artment o	f Health and	-	•	18177
			State Registrar		Ce	rtificate d	of Death		Reg. No.	10111
	Dharini		1. Decedent's Name (First, Middle, Last)					2. Date of De. Month	ath Day Y <i>e</i>	3. Time of Death
	Physici /Medio		Mary J. Minor					May 5,	2005	12:55a M
	Examir		4a. Facility Name (If not institution, give st	treet and number)		4b. City, Tow	m, or Location of Dea	ith	4c. County of D	Death
			National Lutheran	Home		Rockv			Montgor	nery
	Funeral		5. Social Security Number 6. Sex	7. Age (li	yrs. last birthday) 98 Yrs.	If Under 1 Ye Months Da		s. 8. Date of Bird (Month, Da	th year) 9. 5, 1906 Mu	Birthplace (State or Foreign Country)
	Director		379-44-7270	1VI 2/42 I	98 Yrs.			Uct. 2	5, 1906 Mt	rfeesboro,NC
	p s		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits
	sho	5	MD Montgom		Silver					1 TYPes 2 □ No
	% 86-f	ect	10e. Street and Number	icry	DIIVEI	10f. Zip Cod			10g. Citizen of Wha	41
	with t	by Funeral Director								•
	s 23	srai	4108 Conger Street	2. Was Decedent Eve	rio II C 12	2090		Specify Ves or No	United S	States American Indian,
	er de Item	ğ	11. Marital Status 1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 ☐ XNo	1110.3.	If Yes, specify (of Hispanic Origin? (Cuban, Mexican, Pue	rto Rican, etc.)	Black, V	Vhite, etc.
36	rs aft	Į.	3 XWidowed 4 Divorced	If Yes, Give Year or Dates:	1	1 ☐ Yes 2 🛣	No Specify:		Specify:	Black
윽	within 72 hours after death with the Maryland ane. then "neturel", or Items 23e or 28e-f show he Medical Examiner must be notified at	ed	15. Decedent's Educ		16a. Dece	dent's Usual Oc	cupation		16b. Kind of Busine	ess/Industry
5	in 72	piet	(Specify only highest grade	completed)	(Give	kind of work do DO NOT use re	one during most of we tired)	orking		,
7	iene iene	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Teache	r		Educati	on
D	fillec I Hyg othe	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle,	Maiden Sumame)	
<u>a</u>	lid be ked a ic ev	To B	Thomas Pierce				Annie	J. Lewis	3	
a _Z	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importents if item 27 is marked other then "neturel", or Items 23e or 28e-f show minimum or other treumatic event, the Medical Examiner must be notified at once.	_	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Maili	ng Address (Str	reet and Number or F	Rural Route Numbe	er, City or Town, Stat	e, Zip Code)
Baltimore, Maryland 21215-0036	alth a		Doris E. Singfield	/Daughter	4108	Conger	St., Silv	ver Sprin	ng, MD 209	06
ē,	s 1 a of Hei item othe		20a. Method of Disposition	-	20b. Place of Dispo			Date	20c. Location - City	
Ë	Page ento		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Lincoln 1			09/2005	Suitland,	MD
薰	nit.		21. Signatur Funeral Service Ligenser							vice, Inc.
ä	Depar Impor eny ir		André Thom	man	7	400 Geo	rgia Ave.	N.W. Wa	ash., D.C.	20012
	-		23a. Part1. Enter the disease, or complic	ations that caused the	death. Do not en	ter the mode of	ying, such as cardia	ac or respiratory as	rrest,	Approximate Interval Between
	Physician	9	Immediate Cause (Final							
1	/Medical		disease or condition resulting in death)	Due to (or as a co	onsequence of):	PC /11	-green	9 00	WHILL IN	years
	Examiner						V			/
		ĕ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of):					
	uted id ansit	Examiner	Cause (Disease or injury that initiated events							
o,	be executed ician and burial-transit		resulting in death) Last	Due to (or as a co	onsequence of):					
760,	e ys	cai	d.							
68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as It	Physician/Med	IF FEMALE:							
Вох	th ca endii r usa	an/l	23b. Was decedent pregnant 23	lc. If yes, outcome of p 1 Live birth 2		⊒Ectopic pregna	ancv		23d. Date of	•
-	ed fo	sici	in the past 12 months? 1 Yes 2 No	4☐Pregnant at tim 9☐Unknown		Other (specify			Month	Day Year
P.O.	at the	h	9 Unknown		1	0				
	es the	by	Part II. Other significant conditions cont	ributing to death but n	ot resulting in the u	inderlying cayse	given in Part I.			e to the cause of death?
ğ	equir sen s ould	ted	(0)0100	y wu	2	and .	Leber .	101	Yes 2 Ho 3	Probably 4 Unknown
ပ္ပ	m (2) (3)	ple		/				24a. Was		autopsy findings available to completion of cause of
<u> </u>		Completed by						perfo 1 ☐ Yes	rmed2 deatl	h? Yes 2□No
ita	sicien: Th certificate irector, pag	Be (25. Was case referred to medical examiner?					eath (Check only o	one)	
_	S = =	2	1 ☐ Yes 2 ☐ No	ospital: 1 Inpatient	2 ER/Outpatier	nt 3 DOA	Other: 4 Nursing	Home 5 ☐ Resid	dence 6 Other (S	Specify)
0 0	Attending Physicien: r death. sctor: After this certific. by the funeral director,		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time o Injury	of 28c. I	njury at Work?	28d. Describe	how injury occurred	
000	endi eath. or: A the fu	cati	2 Accident investigation			М	1 ☐ Yes 2 ☐ No			
Division of Vital Records,	r Att ter d irect	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (\$		reet, factory, off	ice	28f. Location (S City or Tox		r Rural Route Number,
	Hospitel or 14 hours afte Funerel Dire tely filled in t			1				1		
	Hosp 14 ho Fune tely f	ica	(Check only 2 Medicel Examin	icien: To the best of mer. On the basis of ex	amination and/or in					
	To the Hospitel or Attending Phy within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	Medical	29b. Signature/and title of certifier	and manner stated		290~Lio	ense number	T	29d. Date signed (M	onth, Day, Year)
	5 ± ₹ 5		(V . 0.01). Cence	6 NT	()	21721		11400 0	2 " 36
			e care u	1 0000		B: "	- , , , , (my s	12001
	5		30. Name and address of person who con Charles W. Kares	•			, Damascu	s. MD 20	0872	
	- CA	to					,	,		
	Sta Regist		31. Date filed (Month, Day, Year) NAY 1 3 20	105 Mague	Signature	perel				

Terri Jo Miller 05-03524 **RPD**

)	24		- State Unpend Item	State of Ma 23a&27 per	aryland/Depa me G845 _C 7	artment of I	Health and	Mental Hy	giene	05	18178		
			Decedent's Name (First, Middle, La					2. Date of De	ath		3. Time of Death		
	Physici /Medic		Terri	0	Miller			Month May 2	Day 12005	Year	2040 P ^M		
	Examir		4a. Facility Name (If not institution, given 15429 Westwood Ro			4b. City, Town, Cumber1	or Location of Deat and			y of Death			
3	Funeral Director		212-76-1124	IDM ADE	e (In yrs. last birthday) •5	If Under 1 Year Months Days		8. Date of Bin (Month, Da Jul 11,	1959	9. Birthpla Count V	ace (State or Foreign		
()	aryland show	٥٢	Usual Residence of Decedent 10a. State 10b. County MD Allega	nv	10c. City, Town or Lo	perland	····			10	Od. Inside City Limits		
	ith the Marylar or 28a-f show e retified at	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of				
	s 23a	ral	15429 Westwood		- 110 In		21502			SA			
920	ges 1 and 2 should be illed within 72 hours after death with the Maryland tof Heatth and Mental Hygiene. If item 27 is marked other than "natural", or itams 23a or 28a-f show or other traumatic event, It a Medical Ever in er must be ruitling at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed * Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 1 If Yes, Give Year or Dates:	everin U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer Specify:	ipecity Yes or No to Rican, etc.)		ice - America ack, White, e ^{ify:} white	etc.		
15-0	"natural", or	Completed	15. Decedent's E (Specify only highest gr	ducation	16a. Dece	dent's Usual Occu kind of work done	during most of wo	rking	16b. Kind of E				
2121	d within giene. rr then	omo	Elementary/Secondary (0-12)	College (1-4or 5	Labore	DO NOT use retire	od)		Creo Pl	ant	-		
land	2 should be filed withir and Mental Hygiene. Is marked other than sumatic event, Italia	To Be C	17. Father's Name (First, Middle, Last Norment Merritt	•			18. Mother's Nad	me (First, Middle Merritt	, Maiden Suma	me)			
Mary	C1 60 50 60		19a. Informant's Name/Relationship (Туре, Print) SON	19b. Mailii 129	ng Address (Street 18 St. Ge	and Number or Ri orge's Lar	ne Mt. S	өг, City or Towr avage	n, State, Zip (^{Code)} 21545		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or othar tr once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Speci		20b. Place of Dispo cemetery, crea Scarpelli Fu	matory or other pla		Date 5/27/2005	20c. Location		wn, State		
Baltir	permit. F Departme Importar any injur		21. Signature of Funeral Service Lice		1 11 25		li Funeral H						
			23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between										
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	u	lerotic Ca	rdiovascu	ılar Dise	ase			Onset and Death		
	Examiner		Sequentially fist conditions.	b	a consequence of):								
	uted d ansit	Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):								
8760,	ate be executed thysician and the burial-transit	al Exa	resulting in death) Last	Due to (or as	a consequence of):					-			
မ	ate hy the	Medical	IF FEMALE:	d	. 27								
D. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnanc Other (specify)	у			ate of deliver onth [y Day Year		
, P.O.	res that the de igned by the be detached	y Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did t	obacco use con	tribute to the	e cause of death?		
ords	w require been sig should b	eted t						1 🗆	Yes 2 □ No	3 Proba	bly 4 cnknown		
Division of Vital Records,	The law ate has b	Completed						24a. Was auto perfo	psy ormed?	prior to com death?	sy findings available pletion of cause of		
/ital	Physician: The I this certificate ha ral director, page	Be	25. Was case referred to medical examiner?	Manital				ath (Check only					
of		n: To	1 🔯 Yes 2 🗌 No 27. Manner of Death	Hospital: 1 Inpatie		IL SU DOA		fome 5 Resi	dence 6 🖾 Oti how injury occu		At Scene		
sion	Attending I ir death. ector: After by the funer	cation	1 ♣ Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	n	Year) Injury		rk?]Yes 2□No						
Divi	tal or Attences after death al Director: ed in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined		ury - At home, farm, str c. (Specify)	reet, factory, office		28f. Location (City or To	Street and Num wn, State)	ber or Rural	Route Number,		
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medicai	29a. Certifier (Check only one) 1 Certifying Pl 2 Medical Example	nysician: To the best of miner: On the basis of and manner sta	of my knowledge, death examination and/or in ited.	h occurred at the ti vestigation, in my	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and m date and place,	anner as sta , and due to t	ited. the cause(s)		
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	mellan	e mo	29c. Licens OC			29d. Date signe May 22,		lay, Year)		
			30. Name and address of person who	completed cause of d	eath (Item 23a) (Type,	Print) 111 P	enn Stree	et Balt	imore,	Maryla	and 21201		
	Sta Registr		31. Date filed (Month, Day, Yéār)	2005 32. Registra	ar's Signature								
DH	MH 17 Rev 1/2	001		2005 Julius	ORIGINA	AL							

			Please	Type or Prii					-		_		
			For	State of M	•				Mental Hy	gien	9005	18179	
			1 - Stete Registrar			Certificate	e of De	eath		Reg. No	5. 000	10172	
	Physicia /Medic		1. Decedent's Name (First, Middle, L	ast)			Nov	ello	2. Date of De Month	Da	3 200	~	1
1	Examin		4a. Facility Name (If not institution, g	ive street and number)	· + -	4b. City,	115	cation of Death	NII J	40	. County of Dea	th	
	Funeral Director		5. Social Security Number 6.		SOLTO pe (In yrs. last bir 73	thday) If Under Yrs. Months	1 Year If	Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da April	th D, Year	9. Bird 932 De	hplace (State or Foreign puntry) laware	n
	ס		Usual Residence of Decedent		T40. 05. X				-			104 (_
	anylar show	_	10a. State 10b. County	. 1 .	10c. City, Town	Castle						10d. fnside City Limits 1 ☐ Yes 2 🛣 No	
	the M	ectc	Delaware New Cas	stre	New C	10f. Zip	Code			10a. C	itizen of What Co	ountry?	-
	Mith A Ba or	Funeral Director	603 Central Ave	nue			720			-	Jnited S		
	death	era	11. Marital Status	12. Was Decedent	Ever in U.S.			anic Origin? (S	pecify Yes or No o Rican, etc.)		14. Race - Ame	erican Indian,	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show appring yor other traumatic event. The New Ical Example of Intelligible and once.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:		1 Tes, spec		Mexican, Puent Specify:	o Rican, etc.)		Black, White Specify: Wh	e, etc. nite	
9-0	nature	ted	15, Decedent's (Specify only highest of		16a.	Decedent's Usua (Give kind of wor life. DO NOT us	I Occupation	n na most of war	tkina	16b. I	Kind of Business	/Industry	
21215-0036	ithin 7 ne.	Completed by	Elementary/Secondary (0-12)	College (1-4or	5+)	_	e retired)		9	,		0	
	filed withi Hygiene. other than		1 I 17. Father's Name (First, Middle, La	nel .		Owner	10	Mother's Nan	ne (First, Middle			Company	
ano	Ibe find Helper of the office	Be	Nicholas V. Cox	51)					IcDonougl		ii Gairiairie)		
Maryland	2 should be I and Mental I is marked o aumatic eve	^C	19a. Informant's Name/Relationship	(Type, Print)	19b	. Maifing Address					or Town, State, .	Zip Code)	
Ma	and 2 sauth ar n 27 is		Carol Hall/Daug		14	4 Riverv	iew D	rive, N	lew Cast	1e,	Delawar	e 19720	
ē,	s 1 ar	0 4	20a. Method of Disposition			Disposition (Nam		May	Date 17.	20c. l	ocation - City or	Town, State	
m	Pages nent of I int: If its ury or o		1 ABurial 2 □ Cremation 3 `4 □ Donation 5 □ Other (Spe		Memor	afë Vetë ial Ceme	rans' tery	2005		Bea	ar. Dela	ware	
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other it once.		21. Signatule of Funeral Service Lic	ensee				f Facility For Fun	erals, I	Э. A.			
<u>-</u>	40 E 2 9		Donned.	S. Hub	<u></u>	103 W.	Stock	cton St	reet, El	lkto	n, Mary	land 21921	_
	Physician		23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	mplications that cause ly one cause on each I	d the death. Do ine.	not enter the mode	e of dying, s	such as cardiac	or respiratory a	rrest,		Approximate Interval Between Oncet and Death	1.
	/Medical Examiner		resulting in death)	ue to (or as	a consequence	zh: ((in .		21	
		<u>.</u>	Sequentially list conditions,	b. K. O. Or as	a consequence	UNTITIC	Mo	W I	allu	J.L.K		a nour:	>
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Chica	10001	AK	2 to 10	7 T	5:500	150)	2 month	10
,	execu n and ial-tra	Exai	that initiated events resulting in death) Last	c. Due to (or as	a consequence	of):)		<u> </u>	2100			8 1101	, kee
160	ysicia e bur	'as		d									
687	rtifical ng phy as th	Jedi	IF FEMALE:						·			-	
P.O. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pro					23d. Date of de Month	livery Day Year	
	that ned b		Part If. Other significant conditions	contributing to death I	out not resulting i	n the underlying ca	ause given i	in Part I.	23e. Did t	obacco	use contribute to	the cause of death?	
of Vital Records,	quire; en sig uld bu	Completed by	Hortic,	4 neuri	15M				1 🗆	Yes 2	2 □ No 3 □ P	robably 4 Dunknowr	1
00	aw re	piet	*)				24a. Was		24b. Were at	utopsy findings available completion of cause of	Э
Ä	The late has page	mo							perfo	rmed? 200 N	death? o 1 ☐ Yes	2 □ No	
/ita	striffication.	Be (25. Was case referred to medical examiner?					6. Place of Dea	ath (Check only	one)			_
)t	ding Physician: The lav n. After this certificate has funeral director, page 2 :	P	1 Yes 2 No		ent 2 ER/Ou						6 Other (Spe	city)	
N (Jing F	ion	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inj (Month, Da		Time of 2 njury M	8c. Injury at Work?	s 2 🗆 No	28d. Describe	riow irij	ary occurred		
Division	Attending or death. ector: After by the fune	ficat	2 Accident investigated and Suicide 6 Could no	be 200 Place of In	iury - At home, fa	ırm, street, factory			28f. Location (Street a	nd Number or R	ural Route Number,	
Diγ	al or A after I Dire	Certification:	4 ☐ Homicide determin	building, e	tc. (Specify)	,,,	,		City or To	wn, Sta	te)		
	To the Hospital or Atlending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the best teminer: On the basis of and manner s	of examination ar	e, death occurred ad/or investigation	at the time, , in my opini	date and place ion, death occu	, and due to the irred at the time,	cause(date ar	s) and manner as nd place, and due	s stated. e to the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of certifier	b		290	License n				ate signed (Mont		
			> XC/ Set	u M.D.			RE.	5-000	0	M.	AY 14,	2005	
	15		30. Name and address of person with STEPHEN M. CAT	no completed cause of	death (Item 23a)	(Type, Print)	NIS 14	CSPITAL	GOUL WO	LF8	ST BALT	0.MO 2128	7
	Sta	ate	31. Date filed (Month, Day, Year)	32, Regist	rar's Signature	-1.0, 10, 10, 1							-
	Regist	rar	MAY 1 7 2005	Kenne	D A	and a							

		•	1 - State of Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Death		ene 0 0 5	18180							
	Physici		1. Decedent's Name (First, Middle, Last) Nave (Since (First, Middle, Last))	2. Date of Death Month	Day Year	3. Time of Death							
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death COCSTAL HOSPICE AT THE LAKE SALISBUCT 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs ROSPICE AT THE Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y)	4c. County of Death VICOMI((ear) 9. Birthp Count								
	show	ŗ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		1	Od. Inside City Limits 1 1 Yes 2 □ No							
	with the M a or 28e-f be notifie	Director	VA Accomack Chincotcague 10e. Street and Number 10f. Zip Code	10g	J. Citizen of What Coun								
36	d within 72 hours after death with the Maryland jeene. rt than "naturel", or Itams 23a or 28e-f show The Modeal Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 SWidowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Americ Black, White,	etc.							
Maryland 21215-0036	"na	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work	king 16	b. Kind of Business/Ind								
yland 2	ould be filed within Mental Hygiene. arked other than atic event, Ire M	To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Nam Myrtla	ne (First, Middle, Ma	ialds								
	permit. Pages 1 and 2 should be filed Deperment of Health and Mental Hyg Importent; if Item 27 is marked othe any injury or other treumatic svant, once.		20a. Method of Disposition 20b. Place of Disposition (Name of	hincokaa	55500 89500	1336							
Baltimore,	permit. Pages Department of i importent: if its any injury or o'				ati Hall, UA								
	/Medical Examiner	/Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and leaves a consequence of: Due to (or as a consequence of: Due to lor as a consequence of: Due to lor as a consequence of:	or respiratory arrest		Approximate Interval Between Onset and Death							
x 68760,	pertificate be executed ding physicien and se as the burial-transit		dicai	dicai	dicai	dicai	dicai	dicai	dicai	dicai	that initiated events resulting in death) Last C. Due to (or as a consequence of): d. IF FEMALE: 23c. If yes, outcome of pregnancy		204 Day 444
.O. Box	that the death certifi ed by the attending detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 pronths? 1 Yes 22 No 9 Unknown		23d. Date of delive Month	Day Year							
rds, P	w requires that been signed b should be deta	ρχ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	No 3 Prob	ne cause of death? ably 4 DUnknown							
al Records,	The law ate has b page 2 sl	Completed		24a. Was an autopsy performed	d? prior to con death?	psy findings available npletion of cause of 2000							
on of Vital	Attanding Physician: Ir death. cetor: After this certifica	ertification; To Be	examiner? 1	th (Check only one) ome 5 Residence 28d. Describe how	ce 6 ☐ Other (Specify injury occurred	d							
Division	P Pite	O	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, S									
	To the Hospitel or At within 24 hours after or To the Funeral Directompletely filled in by	Medical	29a. Certifiler (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated. 29b. Signature and title of persities 29c. License number	rred at the time, date	and place, and due to	the cause(s)							
)	16.0		1002 (MD 0262)	78	5-12	-05							
	り所 Sta	te	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AULD CHALL MS CASTAL HOSPICE P.O. By 31. Date filed (Month, Day, Year) 2 2025 32. Pigistrar's Signature,	1733 5	Zelisbun, "	10 21802							
	Registr		MAY 1 6 2005										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 2005 Year Physician 10:40AM Neal a Cleo /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Lions Manor Nursing Home Cumberland If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jul 25, 1931 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1**√** M 2□ F 235-48-2675 Director 73 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

Is marked other than "natural", or Itams 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov other traumatic event, the Medical Exercit at must be notified at Flintstone MD Allegany 1√2 Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21530 11105 Frank Davis Road NE USA or Itams 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1√7es 2 No lfYes, Give Year or Dates: Korea 1 Never Married 2 Married 1 □ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Driver Truck 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Aulda (Messenger) Neal Riley Neal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sk Department of Health and Important: If Itam 27 is n any injury or other traun once. Beulah Neal wife 11105 Frank Davis Rd Flintstone MD 21530 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Rocky Gap Veterans' Cemetery 5/24/2005 MD 4 ☐ Donation 5 ☐ Other (Specify) Flintstone 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Carcinone /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. the director, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 🗌 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To hours after death, inaral Diractor: After this y filled in by the funeral di 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. To tha 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier May 23, 2005 D33280 completed cause of death (Item 23a) (Type, Print) Cumberland, 40 0 MYD 625 Kent 31 2005 32 Registrar's Signature State Registrar

			1- For State of Maryland / Dep	eartment of Health and Mertificate of Death		enë () () 5	18182
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Media		Howard Eldreth Okeson		05	10 05	8:35 P ^M
	Examir	ier	4a. Facility Name (If not institution, give street and number) Chesapeake Hospice House	4b. City, Town, or Location of Death		4c. County of Dea	ath
	Eupovol		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Linthicum Heigh		Anne Aru	
2	Funeral Director		157-01-9851 ¹ XM 2□F 83 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y August 5	(ear) C	rthplace (State or Foreign ountry) NJ
	pu ,		Usual Residence of Decedent		i lagazo o	, , , _ ,	
	shov	5	10a. State 10b. County 10c. City, Town or L				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	ecto	PA Delaware Twin 0		140	000 - 400 - 0	
	with Sa or	ā	520 Jefferson Street	10f. Zip Code	109	g. Citizen of What C U.S.A.	ountry?
	ms 2%	era		Was Decedent of Hispanic Origin? (Sprif Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Am	erican Indian.
9	or Ite	by Funeral Director	1 □ Never Married 2 □ Married 1 121 Yes 2 □ No		Rican, etc.)	Black, Whi	
903	urel',		3 XWidowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 💢 No Specify:		Specify: W	hite
<u>7</u>	filed within 72 hours after death with the Maryland Hygiene. yther then "neturel", or Items 23a or 28e-f show yth, the Medical Examinat must be notified at	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing 16	6b. Kind of Business	/Industry
12	within then then he w	ошо	Elementary/Secondary (0-12) College (1-4or 5+)	nt Manager		Aluminum	
b	Hygied other		17. Father's Name (First, Middle, Last)		(First, Middle, Ma		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23a or 28e-f show any injury or other treumetic event, the Medical Examinat must be rolling at an	To Be	Stanley Okeson, Sr.	Elsie K	irby		
lan)	2 sho and h is ma			ing Address (Street and Number or Rura	i Route Number, C	City or Town, State,	Zip Code)
	and ealth m 27 her tr			Jefferson St., Tu			
Baltimore,	ges 1 If of H or otl		120 Buriai 2 Cremation 3 Chemoval from State	matory or other place)		c. Location - City or	
븚	it. Pa rtmer rtent: njury		'4 □Donation 5 □Other (Specify) Lawn Cro	ht Cemetery 5-14-	2005 L	inwood, P	A
Ba	permi Depa Impo any ii		7 can 1. 11 Fer 1	2. Name and Address of Facility R.T 11 S. Queen St., R	ising Su	n, MD 21	ome, P.A. 911
			23a. Part. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	Malignon+ 1	Nelon	oma	2 year
	Examiner		Due to (or as a consequence of):	J			J
		Jer	Sequentially list conditions, if any, leaching to him redicte cause. Enter Underlying Cause (Disease or injury				
	cuted nd ransit	Examiner	trial initiated events C.				
Ő,	ate be executed hysician and the burial-transit	I Ex	resulting in death) Last Due to (or as a consequence of):				
8760,		dlcal	d				
9 X	death certifica e attending pla of for use as t	by Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			004 Data 444	P
Вох	death atter	cian	in the past 12 months? 1 Live birth 2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	Day Year
o.	that the de led by the detached	hysi	9 ☐ Unknown				
S, D	8 7 9	oy P	Part II. Other significant conditions contributing to death but not resulting in the t	Inderlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
Record	w require been sign should b				1 🗆 Yes	2 □ No 3 □ P	robably 4 hknown
ecc	aw 1s b	Completed			24a. Was an autopsy	24b. Were at	utopsy findings available completion of cause of
_	Th ate pag	Con			performe 1 ☐ Yes 2 €	d? death? I No 1 ☐ Yes	
Vita	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death		. 1/2	
ot	Physic this sral di): To	1 Yes 2 No		ne 5 Residence 28d. Describe how		pour House
on	Attending Physicien: r death. ector: After this certific. by the funeral director,	atlor	Month, Day Year) Injury 2 ☐ Accident investigation	of 28c. Injury at Work? M 1 □ Yes 2 □ No		.,	
Division of	or Attendi after death. Director: A in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	281. Location (Stree City or Town, S	et and Number or Ri	ural Route Number,
٥	ital or A						
	To the Hospital or within 24 hours afte To the Funerel Dirt completely filled in I	edical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a vestigation, in my opinion, death occurred	and due to the caus ed at the time, dato	se(s) and manner as and place, and due	s stated. to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Mont	h, Day, Year)
•	1 (4	<	TON CY of ON entain	N 1738	(1)	1144 11	2005
4	+ IVA			PEFFUSE Hayn	Ay Ana	lapous M	9 21401
	Sta Registr		31. Date liled (Month, Day, Year) MAY 1 7 2005 MAY 1 7 2005 MAY 1 7 2005		,		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1^{Da} **Physician** 2005 2:45 A.M. May 0del1 Osteen, Jr. Alford /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Hagerstown Washington Avalon Manor Nursing Home If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1X M 2□ F Yrs. 217-42-0377 Director 64 Sept.24,1940 Maryland Usuel Residence of Decedent parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantel Hyglens. Important: if item 27 is marked other than "natural", or items 23e or 28a-f show any lojury or other traumatic event, the Madical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Washington MD Funeral Director Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14014 Marsh Pike 21740 U.S.A. 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 ☐ Married 11 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify. White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Civil Service Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ethel Mae Martindale Alford Odell Osteen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeremy Osteen/Nephew 1032 Beechwood Drive Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Toremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/18/2005 Smithsburg, MD Smithsburg Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death **Physician** chion's Obstructive polonorary disease Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examine To the Hospital or Attanding Physician: The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): inding physician and Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Š 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 110 1 ☐ Yes 2 ☐ HO 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Yes 2 No this Aftar this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred edical Certification: 1 Natural 5 Pending investigation 1 ∏Yes 2 ∏No daath. Director: A 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours af To the Funeral Di complataly fillad is 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

OH YH

Division of Vital Records, P.O. Box 68760,

State

31. Date filed (Month, Da

Praveen Bdarum M.D. 340 Mill St., Hagerstown, MD 32. Pagistrar's Signature 2005

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

10062223

Registrar

item 27 is marked other than "natural", or items 23s or 28s-1 show content raumatic event, the Medical Examiner must be notified at content raumatic event, the Medical Examiner must be notified at content of the cont	1. Deced Mart 4a. Fecil Call 5. Socia 222 Usual R 10a. Sta	istrar ent's Name (First, Midde LON MCKAY 1 by Name (If not institution UETT MANOT Security Number -10-0229	Pruiti on, give stre							2. Date of D Month Mau	Reg. No. Death Day	2005	3. Time of Death 7:30 A
/Medical Examiner uneral rector	4a. Fecil Cal 5. Socia 222 Usual R 10a. Sta	ty Name (If not institution VERT Manor Security Number	on, give stre										7 20 11
Examiner uneral rector	4a. Fecil Cal 5. Socia 222 Usual R 10a. Sta	ty Name (If not institution VERT Manor Security Number	on, give stre										1 /: 2U A
uneral rector	5. Socia 222 Usual R 10a. Sta	vert Manor Security Number			r)		4b. City, Tov	m, or Loc	cation of Dear		4c. (County of Deat	
rector	5. Socia 222 Usual R 10a. Sta	Security Number				Ì	Risi	na S	Sun		C	Cecil	
rector	Usual R 10a. Sta	10 0000	6. Sex		ge (In yrs. la		If Under 1 Y	ear If	Under 24 Hrs	8. Date of E) inth	O Riel	hplace (State or Foreig
	Usual R 10a. Sta	-10-0229	1 🗆 N	2.X)F	98	Yrs.	Months D	ays F	lours Min	March	19,19	707	DE DE
natural; or tems 23s or 28s-1 show beliefed at a remainer must be notified at leted by Funeral Director		sidence of Decedent											
"natural", or items 23a or 28a-1st edical Examinar must be notified leted by Funeral Director	MI 10e. Str	e 10b. Count	у		10c. City,	, Town or Lo	cation						10d. Inside City Limit
"natural", or items 23a or 28s odreal Examinar musit be not leted by Funeral Direc	10e. Str	Ced	cil		Ri	sing S	Sun						1 🗆 Yes 2 🗓 N
"natural", or items 23a o odical Examiner must be odical Examiner must be ieted by Funeral D		et and Number					10f. Zip Co	de			10g. Citiz	zen of What Co	untry?
Instural, or Items 2 offer Examination	1.8	81 Telegra	oh Rd				219	111			us	SA	
edical Examiner leted by Fur	11. Mar	al Status		. Was Deceden	t Ever in U.S	3. 13. V	Vas Decedent	of Hispa	nic Origin? (Specify Yes or to Rican, etc.)	No- 1	14. Race - Ame Black, White	
disalE	1 3 🕏	Never Married 2 Ma		Armed Forces 1 Yes 2 If Yes, Give Year or Dates	X No		Yes 2		Specify:	to rican, etc.)		Specify: Wh	
e E		15. Decede	nt's Educa	tion		16a. Deced	ient's Usual O	ccupatio	n .		16b. Kir	nd of Business/	Industry
		(Specify only high	est grade d	completed)		(Give	kind of work d OO NOT use r	one durii etired)	ng most of wo	orking			
N E	Elem	ntary/Secondary (0-12)		College (1-4or	r 5+)	Home	emaker				Ou	un Home	
C L	17 Fath	er's Name (First, Middle	a, Last)			,,,,,,,,	_,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	18	. Mother's Ne	me (First, Mida			
Be			,							Stange			
To To		muel McKay				40. 44.00						r Town, State, 2	Zin Coda)
r other traum		ormant's Name/Relation					•						up code)
191		rol Patter	son/de	aughter						ng Sun,		21911	Tour State
5		thod of Disposition Burial 2 XCremation	3 □Ber	noval from Stat	200. Pi	ace of Dispo emetery, cren	sition (Name on natory or other	r place)	05-	17-2005		cation - City or	
ry or		Donation 5 Other		novannom otat	R.T	. Fow	rd Fune	ral	Home,	P.A.	Risi	ing Sun	, Maryland
any injury o	21. Sig	eature of Juneral Service	e License	Con	sie					.T. Fow Rising			ome, P.A.
-	23a P	1. Enter the disease,	or complica	tions to at caus	ed he death			-					Approximate
(Vest)	S	ork, or heart failure. Li	st only one	on each	line.						-		Interval Between Onset and Death
cian	diseas	ate Cause (Final or condition g in death)	_ a.	174	ement		06	112	Heime	N. 2 11	JPC.		Moure
lical iner	1630111	g iii deaiii)		Due to (or a	as a consequ	ience of):					1.		1
-	Seque	tially list conditions,	b										
i ei	if any, cause.	tially list conditions, eading to immediate Enter Underlying Disease or injury	2	Due to (or a	as a consequ	ience of):							
rial-transit Examiner	Cause that init	ated events	С.										
burial-transit al Examir	resultin	g in death) Last		Due to (or a	as a consequ	ience of):							
the burial			d.										
												_	
letached for use as Physician/Me	IF FEM	ALE: as decedent pregnant	230	. If yes, outcom	ne of pregnar	ncy	Textania	20001			2	23d. Date of del	
for use as the	in	the past 12 months?		1□Live birth 4□Pregnant	at time of de]Ectopic pregi] Other <i>(speci</i>				_	Month	Day Year
detached t	9	Yes 2 SNo Unknown		9☐ Unknown									
F 4	Part II	Other significant cond	Itions contr	buting to death	but not resu	alting in the u	nderlying caus	se given i	in Part I.	23e. Di	d tobacco u	use contribute to	the cause of death?
2 2		-								1 [⊒Yes 2	No 3□Pr	robabiy 4 Unknov
. page 2 should												DAL W	stance finaling
1pie										24a. W	itopsy	prior to	utopsy findings availat completion of cause o
Page 2										1 ☐ Yes	rformed? s 2 No	death?	2 □ No
Be Co		s case referred to medi	cal					2	6. Place of D	eath (Check on	ly one)		
To B		miner? Yes 200 No	Но	spital:	atient 2 🗆 I	ER/Outpatier	nt 3 DOA	Other:	4 Nursing	Home 5 ☐ Re	esidence (6 □Other (Spe	city)
		ner of Death		28a. Date of Ir (Month, I		28b. Time o		Injury at Work?		28d. Describ	e how injur	ry occurred	
fon tion	Y	Natural 5 Pen	ding stigation	(Month, L	Day Year)	Injury	м		s 2 No				
E E	3 3	Suicide 6 Cou	ld not be	28e. Place of	Injury - At ho	ome farm sti	reet factory o	ffice		28f. Location	n (Street an	nd Number or Ri	ural Route Number,
	4 [Homicide dete	rmined	building,	etc. (Specify	<i>(</i>)	001, 140101), 0			City or	Town, State)	
Medical Certification:	29a. C	ertifier 1 Certif	ying Physical Evamine	cian: To the be	st of my know	wledge, deat	h occurred at	the time,	date and pla-	ce, and due to to	he cause(s)) and manner as	s stated. e to the cause(s)
edi	3	ne)		and manner	stated.			,					
Ž		gnature and title of cert	fier				29c. L	icense n	umber		29d. Dat	te signed (Mont	th, Day, Year)
		news	1				1)	CU	5836	54	Ć	3/16/03	5
		-10	on who com	nleted cause o	of death (Item	23a) (Type	Print)	-	-	CALL TO THE		1.	
,	20. 1/-	no and address of oc-s		. Diotor vauso 0	Godin (HOII)	/ (/ ypo.							
		ne and address of pers			a 0 a !		piet	0 0	110	01011			
	Ne	il Lattin,	MD	101 0	olonia	e Way	. Risin	ig Si	ın, MD	21911			·
State Registrar	No.		MD		olonia istrar's Signa	e Way	, Risir	ig Si	ın, MD	21911			

_			For Stata Registrar	State of Ma	-		artment of Hertificate of L				eneo 0	5	18185
	Dhuaiai		1. Decedent's Name (First, Middle, La	st)						ite of Death		Year	3. Time of Death
	Physici /Medic		Jerry	Dale	PAT	JGH			MAY		14, 200		10:43A. [™]
	Examin	er	4a. Facility Name (If not institution, giv	· ·			4b. City, Town, or	Location o	of Death		4c. County o		_
			GARRETT COUNTY HOS				OAKLAND				GARREI	T	
	Funeral		Social Security Number 6. S	ex 7.Ag S∑M 2□F	e (In yrs. last bin		If Under 1 Year Months Days	If Under Hours	Min. (M	te of Birth onth, Day,	Year)	Coun	
	Director		220-58-1004 Usual Residence of Decedent		53	Yrs.			Jar	. 30,	, 1952	Mar	yland
	and and		10a. State 10b. County		10c. City, Town	or Lo	cation					10	Od. Inside City Limits
	Mary f sh	ō	MD Gar	rett			Stran	nton					1 ☐ Yes 2 🖾 No
	28e	Director	10e. Street and Number	LELL			10f. Zip Code	ILOII		10	g. Citizen of W	hat Coun	trv?
	3a or	٥	3617 Swanton Roa	4				2156	51				,.
	death	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. \	Nas Decedent of His	panic Ori	gin? (Specify Y	es or No-	14. Race		an Indian,
က္	or Ita	Ē	1 Never Married 2 Married	Armed Forces?	No 1075		f Yes, specify Cubar		i, Puerto Rican,	etc.)		, White, e	
8	ours a	by	3 ☐ Widowed 4 ☑Divorced	If Yes, Give Year or Dates:	$\frac{1975}{1984}$		1 □ Yes 2 ဩ No	Specify:			Specify:	Whit	e
2-0	72 hours after death with the Maryland natural', or Itams 23a or 28e-f show deal Examiner must be mailfied at	Completed	15. Decedent's En	fucation		Deceo (Give	dent's Usual Occupa kind of work done di	tion	t of working	1	6b. Kind of Bus	iness/Ind	ustry
2	ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. I	DO NOT use retired)	31 #19 111031	. or working				
21	e filed within al Hygiene. I other than " vent, Ine Me	Cor	12th				Labo					v Mil	.1
P L		Be	17. Father's Name (First, Middle, Last,								faiden Sumame)	
yla	should be nd Mental marked c	10		Samuel		JGH			nily		Amelia		EVANS
Maryland 21215-0036	C 60 50 50		19a. Informant's Name/Relationship (**	1.		g Address (Street a						Code)
	is 1 and 3 of Health itam 27 othar tr		Joseph A. Paugh/	Son		-	7 Swanton sition (Name of	коас	Date				. 2
Baltimore,	Pages nent of P int: If its iry or ot		1 ☐ Burial 2 ☐ Cremation 3 ☐		cerneter	y, cren	natory or other place)	Date	2	Oc. Location - C	aty or 10	wn, State
ξ	permit. Pages Department of Importent: If i any injury or once.		'4 □Donation 5 □ Other (Specif	A.,	Ome	-	Crematory		5/19/05		Morgant		
Bal	Depa Impo Impo any ir		21. Signature of Funeral Service Lice	800			. Name and Address		•		S. Sec		
			230 Borth Enter the disease or som	plications that course	I the death Do		tewart Fu				kland,	Ma.	21550
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	one cause on each li	ne.	IOL BITT	er the mode of dying	, such as	cardiac or respi	latory arre	St,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)		nguin		in						
	Examiner				a consequence of			D / 0	. 12	1			
	TV TUR	- G	Sequentially list conditions if any, leading to immediate	b. Due to (or as	a consequence	of):	-pulm	ova	19 75	Tuli		-1-	
	uted ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	EVOS	ion of		artic o	vaf	+ for	low	14.0		
Ć,	n and ial-tra	Exa	resulting in death) Last	Due to (or as	a consequence	of):	CO)	. 10 t	1000	7		
58760,	icate be executed physician and s the burial-transit	dicai		d	te vep	air	aortic c	tic	Injura	1			
		e e					1						
Вох	attending for use a	J.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetal death	3	Ectopic pregnancy				23d. Date	of deliver	у
Π.	death of for	sicia	in the past 12 months? 1 \(\sum \text{Yes} 2 \sum \text{No} \)	4☐Pregnant at			Other (specify)				Mont	h I	Day Year
P.0	law requires that the death certif as been signed by the attending 2 should be detached for use a.	Physician/M	9 🗌 Unknown						1				
Ś	zires tha signed d be del	by	Part II. Dther significant conditions of	ontributing to death b	ut not resulting in	the ur	nderlying cause give	n in Part I.	23		1/		a cause of death?
ord	w requir been si should	ted	- quariflegia							1 🗌 Yes	2 No 3	Proba	ibly 4 Dunknown
Vital Records,	e law r has be ge 2 sh	Completed	Atherosclevoti	ic Cardi	ovascu	la	1 Disea	se	. 24	a. Was an autopsy		ere autop	sy findings available
<u> </u>	ate pag	Con							10	perform Yes 2	ed? de □ No 12	ath? Yes	2□ No
ita	or Attanding Physiclen: The tree death. Diractor: After this certificate in by the funeral director, pag	Be (25. Was case referred to medical examiner?					26. Place	of Death (Ched	k only one)	1	
of \	Physic this co al dire	2	1XXYes 2□No	Hospital: 1 ☐ Inpatie	ent 2 ER/Out	patien	t 3 DOA Other	4 L NU	rsing Home 5	Resider	nce 6 Other	(Specify,	
ם	ding Phy h. After thi funeral o	on:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da		ime of njury	28c. Injury Work	at	120	escribe how	v injury occurred	aw	otor
Division	tandi eath. or: A	Certification:	2 Accident investigation 3 Suicide 6 Could not b	1127	un		on	es 2. 🗖 (`	V & W	ule c	Olli	SION
\leq	or At fter d firaci n by	Ħ	4 Homicide determined	building, et	c. (Specify)		et, factory, office		28f. Lo	y or Town,			Route Number,
	urs a		00- 0		Zoadwa	-					ulcuor		
	To the Hospital or Attano within 24 hours after dealt To tha Funeral Diractor: completely filled in by the	edicai	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	ysician: To the best niner: On the basis of and manner sta	examination and	death Vor inv	occurred at the time restigation, in my opi	e, date and nion, de <i>a</i> t	d place, and du- th occurred at the	e to the cause time, dat	use(s) and mani te and place, an	ner as sta d due to	ited. the cause(s)
	To the within 2 To tha complet	Mec	29b. Signature and title of certifier	and manner sta	1180.		29c. License	number		29	d. Date signed (Month. E	Jav. Year)
	F 3 F 8		(My de H	allan	111 d			OCME					, /
10	LIA		30. Name and address of person who			Type	Print)				AY 15, 2		
W	T V 13		CAROI HA	71 A-M	mal (moningsa) (ype,	''''' 111 Pe	enn S	treet	Balti	more, M	1ary1	and 21201

POWER PRINCIP WEBSTER PINDER PRINCIP WEBSTER				1 - For State Registrar	State of Ma	-	-	artment of F <i>tificate of</i>		nd Mer		eg. No.	005	181	86
PRILIP WESTER PINDER From the property of the					it)	-					Date of Deat	th	Vara	3. Time o	of Death
Security Number Security N		_		PHILIP WEBST	TER PIND	ER							2005	2:1	4р м
Second Second Processory Second Second Processory Second Second Processory Sec					,			_							
215-14-2810 DOM 30F 81 w. Months Day State Mr. June 2 Don 192 Don											Date of Birth			lane (Otata	
100. Shake 100. Cherry 100.	ľ			215-14-3810						A dise		Vaari	23 Mary	land	ar Fareign
Thomas Franklin Pinder Thomas	-	and wo				10c. City, Town	or Lo	cation					1	0d. Inside C	City Limits
Thomas Franklin Pinder Thomas		Mary Fish	tor	MD Kent		Kenne	ad v	ville						1 🗆 Yes	2.X No
Thomas Franklin Pinder Thomas		n the	lrec				<u> </u>				1	0g. Citiz	zen of What Cour	ntry?	
Thomas Franklin Pinder Thomas		23a c	ralD	13531 Turners	Creek Ro	l •		2164	15			U.	S.A.		
Thomas Franklin Pinder Thomas	36	rs after dea !; or Itame	by Fune	1 ☐ Never Married 2 Married	Armed Forces? 1 X Yes 2 ☐ No If Yes, Give					in? (Specify Puerto Rica	Yes or No- an, etc.)		Black, White,	etc.	
Thomas Franklin Pinder Thomas	9	2 hou	ted	15. Decedent's Ed	ucation		Deced	lent's Usual Occup	ation			16b. Kin	nd of Business/Inc	dustry	
Thomas Franklin Pinder Thomas	215	thin 7	ple			•)	(Give life. l	kind of work done DO NOT use retired	during most d)	of working					
23. Name and address of facility. 24. Name and address of facility. 25. Was cate enforced to medical responsibility. 25. Was cate enforced to medical responsibility. 26. Due to (or as a consequence of): 27. Name and address of facility. 28. Place of Death (Check only only only only only only only only	7	ed wij ygien yerth nerth	Con	8			ne	r - Ope						Elec	ctric
23. Name and address of facility. 24. Name and address of facility. 25. Was cate enforced to medical responsibility. 25. Was cate enforced to medical responsibility. 26. Due to (or as a consequence of): 27. Name and address of facility. 28. Place of Death (Check only only only only only only only only	מש	htal H ad oth	Be		n Dindon							Maiden S	Sumame) \propto	riui	"DIII
23. Name and address of facility. 24. Name and address of facility. 25. Was cate enforced to medical responsibility. 25. Was cate enforced to medical responsibility. 26. Due to (or as a consequence of): 27. Name and address of facility. 28. Place of Death (Check only only only only only only only only	Ž	thould Mark mark	P			19h	Mailin	a Address (Street				City or	Town State Zin	Codel 2	1645
23. Name and address of facility. 24. Name and address of facility. 25. Was cate enforced to medical responsibility. 25. Was cate enforced to medical responsibility. 26. Due to (or as a consequence of): 27. Name and address of facility. 28. Place of Death (Check only only only only only only only only		nd 2 s lith an 27 is r treu			• • • • • • • • • • • • • • • • • • • •										
23. Name and address of facility. 24. Name and address of facility. 25. Was cate enforced to medical responsibility. 25. Was cate enforced to medical responsibility. 26. Due to (or as a consequence of): 27. Name and address of facility. 28. Place of Death (Check only only only only only only only only	ē,	of Heal		·		20b. Place of	Dispo	sition (Name of	1						
Proyection Medical Examiner Examine	Ē	Page nent c								5/16	5/05	Ken	nedyvi	lle,	MD.
Approximate sands as a consequence of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the death of the death o	Balt	permit. Departr Importa any inji		21. Signature of Funeral Service Lic	311		G 22	Name and Addre	ss of Facility	1 Hon	ne of	St	ephen I	. Sc	haec
Provided to Model Call Examiner Provided Call Examiner Condition Condit				23a. Part1. Enter the disease, or comp shock, or beart failure. List only	lications that caused t	he death. Do n	ot ent	er the mode of dyin	ng, such as c	cardiac or re	spiratory arre	est,	≠ MD•	Approxima	te
Due to (or as a consequence of):	E	Physician	0 1	disease or condition	PA	eum	01	210							
Description of the property of				resulting in death)			of):								
The female of th		Lxammer	<u>.</u>	Sequentially list conditions,	b. CON	9 (0	,,,	0(4695					1	0 401	7015
The female of th		ted nsit	nlne	cause. Enter Underlying Cause (Disease or injury	rode to for as a	conquence c	or):								
Section Sect		execun n and al-tra	Exar	that initiated events	C. Due to (or as a	consequence o	of):								
FEMALE 23c. If yes, outcome of pregnancy 1 Livre birth 2 Fetal death 3 Ectopic pregnancy 1 Livre birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery Month Day Year 1 Yes 2 No 9 Unknown 1 Yes 2 No 3 Probably 4 Unknown 1 Yes 2 No 1 Yes 2 No 3 Probably 4 Unknown 1 Yes 2 No 3 Probably 4 Unknown 1 Yes 2 No 1 Yes	760	ysicie		(d										
1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed no completion of cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed no completion of cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed no completion of cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed no completion of cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed no completion of cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed no completion of cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy findings available prior to completion of cause of death? 2 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 Yes 2 No 3 Probably 4 Unknown 4 North	_		Med	IF FEMALE:											
25. Was case referred to medical examiner? 1 Yes		he death ce the attendi	yslclan/I	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal death			′			23			Year
25. Was case referred to medical examiner? 1 Yes		that the by detact		Part II. Other significant conditions of	ontributing to death but	not resulting in	the ur	iderlying cause giv	en in Part I.		23e. Did tob	acco us	se contribute to th	e cause of	death?
25. Was case referred to medical examiner? 1 Yes	rds	quires n sigr									1 TYe	s 2	No 3 □ Prob	ably 4 🗆	Unknown
The state of the s	Reco	The law recate has bee bage 2 shot	omplete						_		autops: perform	y ned?	prior to cor death?	npletion of a	available ause of
The state of the s	Ita	clen: ertifica		examiner?											
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and difference of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. State 31. Date filled (Month, Day, Year) 32. Registrar's Signature 33. Registrar's Signature 34. Registrar's Signature 34. Registrar's Signature 35. Pending investigation 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, Stat		hysla this c	မ	1 ☐ Yes 2X No	1 1 npatien			3 DOA	4 🗆 Nurs					')	
29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 43 Speek Rd 5 Chosferdown U.S. 21420 State 31. Date filed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	<u></u>	Jing F After funera	lon	1 Natural 5 ☐ Pending		Year) 28b. Ti		Wor	k?		Describe ho	w injury	occurred		
29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 43 Speek Rd 5 Chosferdown U.S. 21420 State 31. Date filed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	18	death ctor: y the	flcat	3 ☐ Suicide 6 ☐ Could not be		v - At home, far	m. stre		195 2 114	_	Location (Str	reet and	Number or Rura	l Route Num	iher
29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 43 Speek Rd 5 Chosferdown U.S. 21420 State 31. Date filed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	2	el or A s after il Dire	Certi	4 Homicide	building, etc.	(Specify)	, .,,	701, 140101 y, 011100			City or Town	, State)			,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Transcon 122 Speek Rd 5 Chosfek own U.B. 21420 State 31. Date filed (Month, Day, Year) Registrar's Signature		ne Hospit 24 hours ne Funers bletely fille		(Check only 2 Medical Exam	iner: On the basis of e	examination and	death	occurred at the tin estigation, in my o	ne, date and pinion, death	place, and occurred a	due to the ca t the time, da	use(s) a ate and p	and manner as st place, and due to	ated. the cause(s	5)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Transcon 122 Speek Rd 5 Chosfek own U.B. 21420 State 31. Date filed (Month, Day, Year) Registrar's Signature		To the To the Comp	ž	29b. Signature and title of certifier	A.		-	29c. Licens	e number	0	29	9d. Date	signed (Month, I	Day, Year)	
State 31. Date filed (Month, Day, Year) 2. Registrar's Signature				/ William	DSK-1)	was	an	000	167	89	•	7-	14-00	>	
Clare				William TRAINOR	2, 122	Speek			hoste	e ez four	N Me	۵.	21420		
			. 20.00			's Signature									

05-03397 Please Type or Print in Black Indelible/In/05Ensure All Copies Are Legible. unpend item#23a, 27, 28a-1, Perfile, delible/In/05Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Stephen Potter 1 - For State Registrar Certificate of Death Reg. No: 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Stephen F. Potter 16, 2005 14:00 May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Frederick Frederick Memorial Hospital Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 16, 1963 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 **∑**M 2 □ F 214-94-8859 41 Yrs. Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show the Medical Examiner must be notified at 1. Yes 2 □ No Director Maryland Carrol1 Eldersburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 0 21784 United States 23a permit. Pages 1 and 2 should be filed within 72 hours after death. Department of Health and Mental Hygiene. Importent: If Item 27 Is marked other then "neturel", or Items 23e eny injury or other traumating. 6567 Tydings Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 → Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Richard D. Potter Ann Rowe 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6567 Tydings Court, Eldersburg, MD 21784 Margaret Potter / Wife 20a. Method of Disposition
1 ☐ Burial 2 ☐ Seremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State * 4 □ Donation 5 □ Other (Specify) Frederick Crematory 5/20/2005 Frederick, Maryland 21. Signator of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 Sant. Enter the disease, or complications the Laused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Acute Alcohol Intoxication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine requires that the death certificate be executed burial-transit that initiated events resulting in death) Last nding physician and Due to (or as a consequence of): P.O. Box 68760 Physiclan/Medlcal use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed by the should be detach. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Dunknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1

Yes 2

No 1 Yes 2 No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 【XER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1X Yes 2 No funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Page Date of Injury

Page Month, Day Year) Certification: Fnd jury After 1 Natural 5 Pending 1 ☐ Yes 2 No thours after death. investigation 1:15 P death. 2 Accident 5/16/05 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number City of Town, State) 106 Bracken Ct 3 Suicide filled in by 4 Homicide within 24 hours a To the Funerel D Found at residence Walkersville, Maryland 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar hi

MAY 2 3 2005

LING LT
31. Date filed (Month, Day, Year)

mi

MID

32. Regitrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCME

May 18, 2005

111 Penn Street Baltimore Maryland 21201

			- Togista	partment of Health ertificate of Death	h	Re	g. No.	The state of the s	18188
	Physici	an	1. Decedent's Name (First, Middle, Last)		2.	Date of Deatl Month		2005	3. Time of Death
	/Medic	cal	Samuel I. Posner	4h Chu Taura and anation		May	4c. County		8:00 a M
	Examin	er	4a. Facility Name (If not institution, give street and number) Bedford Court Nursing Home	4b. City, Town, or Location Silver Spri				gomer	·v
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under	er 24 Hrs. o	Date of Birth		9. Birthpi	lace (State or Foreign
	Director		577-09-8540 ¹ X ^{M 2□} F 92 Yrs	Months Days Hours	Min. J	une 27	1912	Mary	land
	pue *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location				10	Od. Inside City Limits
	Manyli feho	ō							1 ∰ Yes 2 □ No
	r 28e	irec	10e. Street and Number	10f. Zip Code		10	Og. Citizen of V	What Coun	try?
	th with	ai D	15115 Interlachen Drive, Apt 409	20906			U. S.	Α.	
	tems erm	by Funeral Directo	11. Marital Status 12. Was Decedent Ever in U.S. 1 Amed Forces?	 Was Decedent of Hispanic O If Yes, specify Cuban, Mexica 	Origin? (Specifican, Puerto Ric	y Yes or No- can, etc.)		e - Americ	
36	rs afte	y Fi	1 Never Married 2 Married 1 Married	1 ☐ Yes 2 🕱 No Specify	fy:		Specify	"Whit	
21215-0036	d within 72 hours after death with the Marylan Jene. r then "naturel", or Items 23s or 28e-1 ehow the Medical Examinal must be notified at			cedent's Usual Occupation			16b. Kind of Bu		
212	thin 7. e. en "n	Completed	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	ve kind of work done during mo a. DO NOT use retired)	ost of working				
7	e filed within 72 hours after death with the Maryland at hygiene. Other then "naturel", or Items 23s or 28e-f ehow vent, the Medical Examinating the rigitled at	Con	5+ A	ttorney		=	Law		
Maryland	ntal H ed otl	Be	17. Father's Name (First, Middle, Last) Harry Posner		Gussie		faiden Sumam	7 0)	
Š	should nd Me mark matic	2		uiling Address (Street and Numi			City or Town.	State. Zip	Code)
B ≥	nd 2 salth ar 27 le			15 Interlachen	Dr.,	Apt. 40	9, Sil	ver §	Reing, Md.
e,	of Hear		20a. Method of Disposition 20b. Place of Disposition	position (Name of rematory or other place)	Date		20c. Location -		
Ē	Page		I L Bunai 21 Cremation 3 L Hemoval from State	avid Mem. Gard	len 5/1	3/05 E	alls C	hurch	, Virginia
Baltimore,	permit. Pages 1 and 2 should be filed w Department of Health and Mental hygies Importent: If item 27 Ie marked other til eny injury or other treumatic event, Im- once.		Conald Cottlemule	22. Name and Address of Faci DANZANSKY – GOLD 1170 Rockville	Pike,	_Rockvi	ille, M	LS, I aryla	INC. and 20852
П			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such a	as cardiac or r	espiratory arre	est,	- 1	Approximate Interval Between Onset and Death
	Pnysician	i i	Immediate Cause (Final disease or condition resulting in death) Pulmonary Embo	lus					B Hours
0	/Medical Examiner		Due to (or as a consequence of):						
L		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						
	cuted nd ransit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events C.						
Ō,	sate be executed obysician and the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):						
8/60	certificate be executed Iding physician and Ise as the burial-transit	dicai							
× 6	leath certific attending p I for use as 1	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy				23d Dat	te of delive	D/
Box	atter atter for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)			Mo		Day Year
Ö.	at the de by the a	hysi	9 Unknown						
S,	as thi	by P		underlying cause given in Part	rt I.				e cause of death?
ecords,	w require been sij should b	ted	delebiovascatai biscase			1 U Ye	s 2 No	3 Proba	ably 4 □Unknown
Rec	e taw has b	Completed	-			24a. Was ar autopsy perform	/ F	Nere autor prior to con death?	osy findings available npletion of cause of
	sicien: The fa certificate has irector, page 2	e Co			(D) ()	1 Yes 2	No 1	Yes	2 No
Vital	Physicien: r this certific ral director,	O B	examiner?		Nursing Home		nce 6 □Oth	er (Specily	•)
100	g Physie this neral dii	n; T		of 28c. Injury at			w injury occurr		/
Š	Attending F r death. ector: After by the funer	atic	1 Matural 5 Pending (Month, Day Year) Injur	M 1 Yes 2	□No				
Division	or Att	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, building, etc. (Specify)	street, factory, office	28f	Location (Str City or Town		er or Rura	l Route Number,
	pitel ours a eral [ath accurred at the time, date :	and place, and	due to the ca	use(s) and ma	nner as st	ated
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, de	eath occurred	at the time, da	ite and place, a	and due to	the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	r	29	d. Date signed	d (Month, L	Day, Year)
	12		V MW House	D30844			May 11,	2005	5
	4			1119 Rockville	e Pike,	Suite	409, R	lockv	ille, Md.
	Sta Registr		31. Date filed (Month, Day, Year) MAY 16 2005 32 Registrar's Signature	barle					

			For	State of Ma	ryland / D	epartment of	Health and		_	e. 8 8 9
	-		Registrar			Certificate o	Dealii	10.7.4.10	Reg. No.	
	Physici /Medic		Decedent's Name (First, Middle, Las Earl	<i>v</i> Erwin Ropk	.a			2. Date of De Month MAY		3. Time of Death 9:10 A. M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town	, or Location of Deat	h	4c. County of [
			VA MARYLAND HEALT	H CARE SYS	TEM		PERRY PC	INT	CE	CIL
	. Funeral		Social Security Number 6. Security Number	W	(In yrs. last birth	Months Day		8. Date of Big	rth 9.	Birthplace (State or Foreign Country)
.:	Director		183-03-7743	2 M 2 L F	86 Y	rs.		Feb. 2	2, 1919	Maryland
四	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
EARL	sho	'n		,	Too. Oxy, Town		Deposit			1 Tyes 2x No
田	he N	Director	Maryland Ceci	-Т			Deposit		10- 00	
A,	within 72 hours after death with the Maryland ene. than "natural", or Items 23c or 28a-1 show the Medical Exercite Intelligial	ā	223 Blythedale Ro	nad.		10f. Zip Code	21904		10g. Citizen of Wha	S.A.
ROPKA,	eath is 23	Funeral	11. Marital Status	12. Was Decedent E	ver in IIS	13 Was Decedent		necify Vec or N		American Indian.
	ter d Item	'n	1 Never Married 2 Married	Armed Forces?		If Yes, specify C	of Hispanic Origin? (S uban, Mexican, Puer	to Rican, etc.)	Black, V	White, etc.
336	irs af	by	3 ☑ Widowed 4 ☐ Divorced	1 🖫 Yes 2 🗌 No If Yes, Give Year or Dates: 1	943-45	1 ☐ Yes 2 🔀 N	lo Specify:		Specify:	White
NA O	2 hou		15. Decedent's Ed	ucation	16a. D	Decedent's Usual Occ	cupation		16b. Kind of Busin	ess/Industry
CL	hin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)			Give kind of work doi life. DO NOT use ret	ne during most of wo ired)	rking		cal Center
SI 21	d wit giene er the	Хоп		College (1-4or 5+ One Year	É E	lectronic	Technicia	n	Perry Poi	nt, Maryland
PHYSICIAN Ind 21215-0	e filed al Hygid other vant, I	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle	e, Maiden Sumame)	
) E	should be nd Mental marked c	To	Emmerd E. R	.opka			C	atherine	e E. Snell	ing
ary	2 should be filed within 72 hours atter death with the Marylan and Mental Hygiene. is marked other than "natural", or Items 23c or 28a-f show is marked other than "natural", or items to provide a sumatic event, it is Medical Exaction to the notified at	·	19a. Informant's Name/Relationship (7	ype, Print)					er, City or Town, Sta	
Z∑.	1 and 2 Health tem 27		Carol E. Slone (Daughter)			Station R	oad, Per	cryville,	MD 21903-1617
KNOWN	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of I cemetery	Disposition (Name of , crematory or other p	place)	Date	20c. Location - City	or Town, State
ΞË	Pages ment of I ant: If it ury or o		4 □ Donation 5 □ Other (Specify		Asbur	y Cemetery	05	/17/05	Port Depo	sit, Maryland
NAME KNOWN TO PHYSICIAN: Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic <u>once</u> .		21. Sign ture of Funeral Service Lizen	6 өө		22. Name and Add		s Son Fr	neral Hom	o P 7
Z =	207 2 2	1 14	Unonas M. te	tttEllow, 5	X.	Perryvil	le, Maryl	and 219	903-0766	е, г.А.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused to one cause on each line	he death. Do no	t enter the mode of o	tying, such as cardia	or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a END STA	GE DEME	NTIA				Onset and Death UNKNOWN
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):				
	LAGIIIIICI	L	Sequentially list conditions,	b	consequence of					
16	led sit	Examlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence or	<i>j</i> .				
~	te be executed ysician and ie burial-transit	xar	that initiated events resulting in death) Last	c Due to (or as a	consequence of):				
760,	siciar buri	calE	T.	d						
89	death certificate i attending physi	edlo		d						
Box 68	nding use a	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o	f pregnancy				23d. Date of	delivery
m	death e atte d for	hysiclan/Medl	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at ti		3 ☐ Ectopic pregnar 5 ☐ Other (specify)			Month	Day Year
P.O.	by the	hys	9 🗆 Unknown	9∐ Unknown						
Ψ.	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by P	Part II. Other significant conditions co	ontributing to death but	not resulting in t	the underlying cause	given in Part I.	23e. Did 1	tobacco use contribut	e to the cause of death?
Division of Vital Records,	v require been sig should b							1 🗆	Yes 2□No 3□	Probably 4 Munknown
S	aw re	ompleted						24a. Was	an 24b. Wer	autopsy findings available to completion of cause of
H	sician: The law certificate has b irector, page 2 s	E						auto perfo 1 Yes	ormed? deat	h? Yes 2□ No
ta		Se C	25. Was case referred to medical				26. Place of Dea	ath (Check only o		100 2010
>		To B	examiner? 1 🗌 Yes 2 X No	Hospital: 1 XInpatien	t 2 ER/Outp	patient 3 DOA	Other: 4 Nursing H	lome 5 Resi	idence 6 Other (Specify)
0	neral		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Tir	me of 28c. In	jury at Vork?	28d. Describe	how injury occurred	
<u>.</u>	andir sath. or: Al	atle	2 Accident investigation				□Yes 2□No			
<u>×</u>	al or Attending Phy s after death. Il Director; After this sd in by the funeral o	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farn (Specify)	n, street, factory, offic	ce ·	28f. Location (City or To	Street and Number o. wn, State)	r Rural Route Number,
	rs aft ral Di	Çer						1		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funera	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sician: To the best of iner: On the basis of e	examination and/	death occurred at the or investigation, in m	time, date and place y opinion, death occu	e, and due to the irred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	thin 2 the other mpler	Med	29b. Signature and title of certifier	and manner state	∌a. ————————————————————————————————————		ense number		29d. Date signed (M	
	7 ™ 7 %		1	_					(IN	
	D		30. Name and address of person who of	completed cause of de-	ath /Item 22=) (T	ivoe Print\	D52739		MAY 14, 2	2005
	1.11						ADE GAGUE	יחסקס אי	V DOTNIM M	ID 21902
	Sta	te	SURESH SHANDELYA 31. Date filed (Month, Day, Year)	32 Registrar	's Signature	TIENTE !	CUICE DIDIE	HI FERR	T FOINI, I	IV 21702
	Registr	·	MAY 1 6 20	05 Bloom	1 1 /					

			For State Registrar	State of Mary		partment of lertificate of			_	giene Reg. No.	05	18190
Ē	Dhysiai	20	1. Decedent's Name (First, Middle, Last)						2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medic		MARK STEVEN	ROBERTSON					MAY	14	2005	
	Examin		4a. Facility Name (If not institution, give s FREDERICK MEM		PITAL	4b. City, Town, FREDE		of Death		1	ounty of Dea	
	Funeral Director		219-94-0713	7. Age (In	yrs. last birthd 38 Yrs	Months Davs		Min	8. Date of Bir (Month, Da Dec 18	th y, Year) 196	C	thplace (State or Foreign ountry) nnsylvania
	and *		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or	Location						10d. Inside City Limits
	Aaryli Sho	៦			damstow							1 ☐ Yes 2 XNo
	28a-	Directo	Maryland Frederick 10e. Street and Number	A	Jamstow	10f. Zip Code				10a. Citize	n of What C	ountry?
	with Ba or		2110-B Pleasant Vi	ew Road		21710				USA		,
	death ms 2;	Funeral		12 Was Decedent Ever	in U.S. 1	Was Decedent of If Yes, specify Cul	Hispanic Ori	gin? (Spec				erican Indian,
50	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-1 show valcal Evaninat the notified at	by Fur	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, specify Cul			tican, etc.)		Black, Whi pecify: Wh:	
2-003e	thou stura	ed	15. Decedent's Edu		16a. De	cedent's Usual Occu	pation				of Business	
2 2	n "nal	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(G lif	ive kind of work done e. DO NOT use retin	during mosi ed)	t of workin	g	1		·
7	d within jiene.	E	12	College (1-401 5+)	Con	struction	Worke	r		Cons	truct	ion
and	e filed al Hygi othar vant, I	BeC	17. Father's Name (First, Middle, Last)						(First, Middle		,	
ā	should be nd Mental markad c matic eve	To E	Raymond Leo Robert	son			Bonn	ie Ar	lene W	right		
a	2 should and Men Is marka aumatic		19a. Informant's Name/Relationship (Ty	oe, Print)	19b. M	ailing Address (Stree	t and Numbe	er or Rural	Route Numbe	er, City or T	Го w п, State,	Zip Code)
, ga	12 tr		Gail Annette Rober			-B Pleasa	nt Vi	ew Rd	. Adam			
9	0 0 .		20a. Method of Disposition 1 Burial 2 X Cremation 3 DR		Ob. Place of Di cemetery, o	sposition (Name of crematory or other pla	ice)	May	-	20c. Loca	tion - City or	Town, State
altimor	nit. Pages artment of ortant: If it injury or o		' 4 □ Donation 5 □ Other (Specify)	Total Homodate	V. Arun	del Cremat	ory	200	5	Odent	on, Ma	aryland
ga	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License	()//_		22. Name and Addr Going Home Reverly L.						ox 784 le, MD 21029
		2,000.00	23a. Part 1. Enter the di ease, or compli shock, or heart failure. List only or	cations that caused the								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	tone 7m	1.00					Onset and Death
	/Medical		resulting in death)	Due to (or as a co	ons uence of):	10.9	isice					
	Examiner			Adult	Pesn.	ratury	distr	e 55	Synd.	rome	_	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	sequence of).			0.00	/			
	be executed ician and burial-transit	Examin	that initiated events	1	vecmon	, h						
Ď,	e exe ian a irial-i		resulting in death) Last	Due to (or as a co	ensequence of):							
9/80	cate be executed by sician and the burial-transit	dical										
٥	certificate Iding phys		IF FEMALE:									
ROX	eath certific attending p I for use as I	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐		3 Ectopic pregnance	су			23	d. Date of de Month	Day Year
	the death y the atten ached for u	sici	1 Yes 2 No	4 Pregnant at time 9 Unknown	e of death	5 ☐ Other (specify)		-				32,
Ţ.	res that the de signed by the a I be detached f	Phy	Part II. Other significant conditions cor	tribution to doub but n	at secution in th		nuan in Bost I		220 Did t	oba con usa	. contribute t	o the cause of death?
Ś	res th	by	Part II. Other significant conditions con	ithipothis to death put he	or resulting in th	e underlying cause g	iven in Faiti.	•		Yes 2		robably 4 Unknown
ecords,	h require been si should b	ted							, ,	103 2	140 0	
ec	The law requires that ite has been signed b age 2 should be deta	Completed			-				24a. Was autor		prior to	utopsy findings available completion of cause of
<u> </u>		Co								2 No	death? 1 ☐ Ye	s 2 No
Vital H	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:			han		(Check only o	-		
0	Physi this c	은	1 195 2 190	1 LY Inpatient	2 ER/Outpa	Ment 3 DOA			e 5 Resi			ecify)
	ittanding F death. ctor: After y the funera	atlon:	27. Manney of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Tim Inju	ry Wi	iry at ork?]Yes 2 □		8d. Describe I	now injury	occurred	
DIVISION	of or Attano after death Diractor: d in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (5	At home, farm, Specify)	street, factory, office		2	8f. Location (: City or To		Number or R	ural Route Number,
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Diractor: After this certific completely filled in by the funeral director,	edical C		sician: To the best of m ner: On the basis of exa and manner stated	amination and/o							
	To tha within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licer	ise number			29d. Date	signed (Mon	th, Day, Year)
	C > F 0		1	ander-	MO	D611	72			5-	15-0	5
4	17		30. Name and address of person who	pleted cause of death	(Item 23a) (Tv		12			J -		ore and the second
1	26		Ronnie Jacobs M.D.	-			k, MD	2170	1			
	Sta	ite	31. Date filed (Month, Day, Year)	32. Sigistrar's	Signature		,					
	Regist		MAY 17 20	05 Bleeve	· J.	Sneet ,						
DH	IMH 17 Rev 1/2	001										

DHMH 17 Rev 1/2001

ORIGINAL

			1 ⊷ For State Registrar	State of Maryland		artment of H rtificate of L		ntal Hygie	.000	18191
	° Physici	. 4	1. Decedemis Name (First, Middle, Last	L Roce	5R (Date of Death	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of Death	3
		•	Shady Grove Advent	tist Hospital		Rockville			Montgome	ry
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. Ia X M 2 ☐ F	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Ye		place (State or Foreign ntry)
	Director		512-40-8636 Usual Residence of Decedent	63	113.			Feb 20,	1942 Kans	sas
	ryland how		10a. State 10b. County	10c. City	, Town or Lo	ocation			1	10d. Inside City Limits
	Ba-f s	cto	Maryland Montgomer	ry Nort	h Poto					1 ☐ Yes ŽŽŽNo
	with the	Dire	10e. Street and Number 12304 Mosel Terrac			10f. Zip Code 20878		US.	Citizen of What Coul	ntry?
	death ms 23	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S	6. 13.	Was Decedent of Hi	ispanic Origin? (Speci	fv Yes or No-	14. Race - Americ	
စ္တ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 ie marked other then "natural", or Items 23a or 28a-f show say injury or other treumetic event. It is Modical Examitient highlight at an ance.	/ Fur	1 ☐ Never Married 2 🕅 Married	Armed Forces? 1 X Yes 2 ☐ No If Yes, Give		it Yes, sp <i>ec</i> ity Cuba 1 □ Yes 2 ☒ No	n, Mexican, Puerto Ri	can, etc.)	Black, White,	
21215-0036	hours tural',	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates: 1966-	72			16h	Whit	
75	nin 72 In "na Madic	Completed	(Specify only highest grad		(Give	kind of work done of DO NOT use retired	ation during most of working ()	100	. Killa of basillessylli	dustry
	ed with	Com		5+	Manag	ger			onstructio	on
Maryland	ntal H	Be	17. Father's Name (First, Middle, Last) Roland Paul Rogers				18. Mother's Name (A		len Sumame)	
Ž	should nd Mei mark imetic	은	19a. Informant's Name/Relationship (7)		19b. Mailir	ng Address (Street a	and Number or Rural F		tv or Town. State. Zin	Code)
	alth ar	2	Lola N. Rogers/wit				errace N. 1			
ore,	of He		20a. Method of Disposition 1 ☐ Burial 2 🕅 Cremation 3 ☐ F	20b. Pla		esition (Name of matory or other place		e 20c	Location - City or To	own, State
Baltimore,	tment tent: tent:	l n	' 4 □ Donation 5 □ Other (Specify)	W.A.		Cremato	ry 2005	Ode	enton, Mar	
Ba	permi Departimon Impon eny ir	0 72	21. Signature of Funeral Service Lice s	1+++			Cremation			
			23a. Part1. Enter the disease, or complishock, or heart failure. List only of	lications that caused the death.	Do not ent	er the mode of dying	g, such as cardiac or r	espiratory arrest,	Larksville	Approximate Interval Between
	Pnysician	i u	Immediate Cause (Final disease or condition	MERSTATIC-	ADER	20 GARCII	YO AMOU	THE GL	nn :	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequent			***************************************			
		er	n any, leading to introediate	b. Dué to (or às a conséqui	ence of).					
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c.						
ő,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a consequent	ence of):	_				
68760,		edical		d						
Box (± 0 a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan		7e			23d. Date of delive	əry
	it the death cer by the attendir tached for use	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal of dead of the 2 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
P. 0.	that the		9 ☐ Unknown Part II. Other significent conditions co		iting in the u	nderlying cause give	en in Part I	23e. Did tobaco	o use contribute to the	he cause of death?
Records,	The taw requires that the tee by the tee been signed by the bage 2 should be detache	d by							2 No 3 Prob	1/
CO	aw requir ss been si 2 should	olete						24a. Was an	24b. Were auto	psy findings available
- R		Completed						autopsy performed	? death?	mpletion of cause of
Vital	ysicien: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	Hospital:		0	26. Place of Death (Check only one)		
		. To	1 ☐ Yes 2 No Control	1 inpatient 2 L	R/Outpatien 28b. Time of		4 Nursing Home	5 Residence	6 ☐Other (Specification)	y)
ion	Attending Physicien: or death. ector: After this certifici by the funeral director, I	ation	1 Natural 5 ☐ Pending investigation	(Month, Day Year)	Injury	Work	(? Yes 2 □ No		,,,,	
Division of	il or Atte after dea Directo	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, str	eet, factory, office	28	f. Location (Street City or Town, St	and Number or Rura ate)	l Route Number,
Ω	Hospital or Attending I 24 hours after death. Funerel Director: After tely filled in by the funer		29a. Certifier 1X Certifying Phy	sician: To the best of my know	dodgo dosti		and place and	d div = 3 = 45 =	/-\	
3	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only 2 Medicel Exemi	iner: On the basis of examination and manner stated.	on and/or in	vestigation, in my op	pinion, death occurred	at the time, date a	n(s) and manner as si and place, and due to	ated. the cause(s)
	To the within 2 To the complet	Σ	29br Signature and title of certifier		1	29c. License	number	29d. I	Date signed (Month,	Day, Year)
			jame le.	Scowy, W	(1)	Do4	- 285	MY	14,2	005
			30. Name and address of person who co	ompleted cause of death (Item 0707 N	23a) (Type,	TENTER	DRIVE RO	CKUICIÉ	MADVIANT	20850
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ure				1 24	
	Registr	ar	MAY 1 7 20	IUJ JAMES J	J. /	DB4/2				

/Medica		1. Decedent's Name (First, Middle) Jose Isidro M JOSE ISIDRO MA	ast) artinez		-	2. Date of Dea	Day Yea	. 14
		4a. Facility Name (If not institution, gi		4b. City. Town	, or Location of Deal	MAY	21, 2005 4c. County of De	
LAGIIIIII	ar	3709 TAYLOR STRE			SVILLE		PRINCE G	
uneral			LL Sex 7. Age (In yrs. last b	birthday) If Under 1 Yea	r If Under 24 Hrs		h 9 F	Birthplace (State or Foreign
irector		218-61-0502	1⊠M 2□F 32	Yrs. Months Day	s Hours Min	Jan. 4	y, Year)	Country)
		Usual Residence of Decedent					12/3	
show		10a. State 10b. County		wn or Location				10d. Inside City Limits
Ba-f	5		George's Bren	twood				1 X Yes 2 □ No
or 2		10e. Street and Number		10f. Zip Code			10g. Citizen of What	Country?
s 23s	ra l	3709 Taylor Stre		2072				of El Salvado
inear in an eventury great in a naturel, or items 23a or 28a-f sho other treumetic event, the Madical Examiliar treust be mullised at	by Funeral Director	11. Marital Status 1 ▼ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Control of Image 2 1 N N 1	ıban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	Black, W	merican Indian, hite, etc. Hispanic
fure	be	15. Decedent's 8	1	ia. Decedent's Usual Occ	unation			<u> </u>
n "n	Completed	(Specify only highest g	rade completed)	(Give kind of work dor life. DO NOT use reti	ne during most of wa	rking	16b. Kind of Busines	samuustry
tha	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Repairman	•		C+ Tulco	Institute
marked other	Be C	17. Father's Name (First, Middle, Las		repetition.	18. Mother's Na	me (First, Middle,	Maiden Sumame)	Institute
arked o	9	Salvador Martine	Z		Estani	slao Riv	as	
is ma eume		19a. Informant's Name/Relationship	(Type, Print) 19	b. Mailing Address (Stre				, Zip Code)
27 is		Maria D. Velasq	uez - Sister 3	3709 Taylor	Street. H	rentwood	. Marvlan	d 20722
item 27 i		20a. Method of Disposition	20b. Place	of Disposition (Name of tery, crematory or other p	lace)	Date	20c. Location - City	
Ty or		1 ☑ Burial 2 ☐ Cremation 3 (`4 ☐ Donation 5 ☐ Other (Spec	Artemoval Both State	nterio del I	I .	9/2005	San Migu	il, El Salvador
Importent: If ite eny injury or ot once.	Ì	21. Signature of Funeral Service Lice	onsee 7	22. Name and Add			uneral Hor	
8 5 8		H Constan	ce Basch	4739 Ba1			tsville, N	
		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the death. Do	o not enter the mode of d	ying, such as cardia	c or respiratory ar	rest,	Approximate Interval Between
sician		Immediate Cause (Final disease or condition	Acute Carbon M	Monoxide Int	oxication	and Alc	ohol lise	Onset and Death
ledical	•	resulting in death)	Due to (or as a consequence				01101 050	
aminer		Sequentially list conditions	b					
Ħ.	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	e of):				
physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequence	9.0():				
			Due to for as a consequence	e 01).				
L (0	dical		d					
attending for use as	Me	IF FEMALE:	23c. If yes, outcome of pregnancy				1 02d Date of d	I-live-
	clan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death	th 3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су		23d. Date of d Month	Day Year
# o	=	1 ☐ Yes 2 ☐ No	9□ Unknown	3 La Outer (apeciny)				
# o	S	9 🗌 Unknown						
# o	y Physician/M		contributing to death but not resulting	in the underlying cause of	given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
gned by the atte	2		contributing to death but not resulting	in the underlying cause o	given in Part I.	23e. Did to	. /	to the cause of death?
gned by the atte	2		contributing to death but not resulting	in the underlying cause o	given in Part I.	1 □ Y	es 2 No 3 1	Probably 4 Unknown
as been signed by the atte	2		contributing to death but not resulting	in the underlying cause o	piven in Part I.		an 24b. Were prior to	Probably 4 Unknown autopsy findings available ocompletion of cause of
as been signed by the atte	Completed by	Part II. Other significant conditions	contributing to death but not resulting	in the underlying cause ς		1 Yes	an sy med? 24b. Were prior to death? 2 \(\text{No} \)	Probably 4 Unknown autopsy findings available ocompletion of cause of
as been signed by the atte	Be Completed by	Part II. Other significant conditions 25. Was case referred to medical examiner?	Hospitals		26. Place of De	1 Y Y 24a. Was a autop: perfor 1 Yes	an 24b. Were sy prior to death 12 No 12 Ye	Probably 4 Unknown autopsy findings available o completion of cause of second 2 No
his certificate has been signed by the attering director, page 2 should be detached for	lo Be Completed by	Part II. Other significant conditions 25. Was case referred to medical	Hospital: 1 ☐ Inpatient 2 ☐ ER/C	Outpatient 3□ DOA	26, Place of Der ther: 4 \(\) Nursing F	1 Yas autopi perior 1 Yes ath Check onl or lome 5 Resid	an 24b. Were prior to death 22 No 12 Years ence 6 X ther (Sc	Probably 4 Unknown autopsy findings available o completion of cause of second 2 No
After this certificate has been signed by the atter funeral director, page 2 should be detached for	lo Be Completed by	Part II. Other significant conditions 25. Was case referred to medical examiner? 1X Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatient 2 ER/C 28a. Date of Injury 28b. Found: Day Year)	Outpatient 3 DOA Time of 28c. In	26. Place of De; ther: 4 □ Nursing F ury at ork?	24a. Was a autop: perfor 1 Ves ath Check onl or lome 5 Resid 28d. Describe h	an 24b. Were sy prior to death 12 No 12 Ye	Probably 4 Unknown autopsy findings available o completion of cause of ass 2 No Decify) SCENE
After this certificate has been signed by the atter funeral director, page 2 should be detached for	lo Be Completed by	Part II. Other significant conditions 25. Was case referred to medical examiner? 1 X Yes 2 No 27. Manner of Death 1 Natural 5 Pending 21 X Accident investigatic 3 Suicide 6 Could not	Hospital: 1 Inpatient 2 ER/C 28a. Date of Injury 28b. Found: Day Year 50	Outpatient 3 DOA Time of 28c. In: In: O M 10	26. Place of Der ther: 4 □ Nursing F ury at ork? □ Yes 2 □ No	24a. Was a autopy perfor 1 Yes ath Check onl or 28d. Describe h Inhaled truck	an sy 24b. Were sy prior to death med? 22 No 102 Years ow injury occurred exhaust f	autopsy findings available occumpletion of cause of pas 2 No
After this certificate has been signed by the atter funeral director, page 2 should be detached for	lo Be Completed by	Part II. Other significant conditions 25. Was case referred to medical examiner? 1X Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 X Accident investigation	Hospital: 1 Inpatient 2 ER/C 28a. Date of Injury 28b. Found	Outpatient 3 DOA Time of 28c. In Time y M 1 (farm, street, factory, office	26. Place of Der ther: 4 □ Nursing F ury at ork? □ Yes 2 □ No	24a. Was a autopy perfor 1 Yes ath Check onl or 28d. Describe h Inhaled truck	an sy 24b. Were sy prior to death med? 22 No 102 Years ow injury occurred exhaust f	autopsy findings available occumpletion of cause of pas 2 No
After this certificate has been signed by the atter funeral director, page 2 should be detached for	Certification: To Be Completed by	Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigating investigating determined 4 Homicide 6 Could not 1 determined	Hospital: 1 Inpatient 2 ER/C 28a. Date of Injury 28b. Found: Day Year) 28b. Place of Injury - At home, building, etc. (Specify) Found in structory hysicien: To the best of my knowledge miner: On the basis of examination at the structory of	Dutpatient 3 DOA Time of 28c. In Inity M 1[farm, street, factory, office.]	26. Place of Derther: 4 Nursing Fury at ork? Yes 2 No	24a. Was a autop: perfor 1 Yes ath Check onl or lome 5 Resid 28d. Describe h. Inhaled truck 28f. Location (S City or Tow Hyattsv:	an sy 24b. Were sy med? 24b. Were sy med? 22 No 12 Ye ence 6 Nother (Sp ow injury occurred exhaust fitreet and Number or in, State) 3709 Tille, Md	autopsy findings available of completion of cause of less 2 No lessify) SCENE cumes from Rural Route Number, last stated
After this certificate has been signed by the atter funeral director, page 2 should be detached for	ledical Certification; To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigate 3 Suicide 6 Could not 1 determined 29a. Certifler (Check only 2 Medical Exe	Hospital: 1 Inpatient 2 ER/C 28a. Date of Injury 28b. Found: Day Year 7 28b. Place of Injury At home, building, etc. (Specify) Found in structory	Dutpatient 3 DOA Time of 28c. In: W Thirty M 1[Amount of the content of the cont	26. Place of Derther: 4 Nursing Fury at ork? Yes 2 No	24a. Was a autop: perfor 1 Yes ath Check onl or 1 Yes ath Check on 1 Yes ath Check on 1 Yes ath Check on 1 Yes ath Check on 1 Yes ath Check on 1 Yes ath Check on 1 Yes at 1 Yes	an sy 24b. Were sy med? 24b. Were sy med? 22 No 12 Ye ence 6 Nother (Sp ow injury occurred exhaust fitreet and Number or in, State) 3709 Tille, Md	autopsy findings available of completion of cause of less 2 No Decify) SCENE Fumes from Rural Route Number, laylor St. as stated. Le to the cause(s)
ne Funerel Director: After this certificate has been signed by the attended in by the funeral director, page 2 should be detached for	ledical Certification; To Be Completed by	Part II. Other significant conditions 25. Was case referred to medical examiner? 1	Hospital: 1 Inpatient 2 ER/C 28a. Date of Injury 28b. Found: Day Year) 28b. Place of Injury - At home, building, etc. (Specify) Found in structory hysicien: To the best of my knowledge miner: On the basis of examination at the structory of	Dutpatient 3 DOA Time of 28c. In: W Thirty M 1[Amount of the content of the cont	26. Place of Deather: 4 Nursing Fury at ork? Yes 2 No	24a. Was a autop: perfor 1 Yes ath Check onl or 1 Myes ath Check onl or 1 Myes 28d. Describe h Inhaled truck 28f. Location (S City or Tow Hyattsv: 0, and due to the curred at the time, described in the curred at	an sy sy med? 24b. Were sy med? 22 No 24b. Were sy prior to death? 20 No 24b. Were sy prior to death? 20 No 24b. Were sy prior to death? 24b. Were sy prior to death and so and s	autopsy findings available occompletion of cause of as 2 No secify) SCENE fumes from Rural Route Number, aylor St. as stated. ue to the cause(s) mth, Day, Year)
After this certificate has been signed by the atter funeral director, page 2 should be detached for	ledical Certification; To Be Completed by	25. Was case referred to medical examiner? 1X Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigate 3 Suicide 6 Could not 1 determined 29a. Certifler (Check only one) 2X Medical Exe	Hospital: 1 Inpatient 2 ER/C 28a. Date of Injury 28b. Found: Day Year) 28b. Place of Injury - At home, building, etc. (Specify) Found in struction: To the best of my knowledge miner: On the basis of examination a and manner stated.	Dutpatient 3 DOA Time of 28c. In W To A 1 farm, street, factory, office. Reg., death occurred at the ind/or investigation, in my 29c. Licer	26. Place of Derther: 4 Nursing Fury at ork? Yes 2 No	24a. Was a autop: perfor 1 Yes ath Check onl or 1 Myes ath Check onl or 1 Myes 28d. Describe h Inhaled truck 28f. Location (S City or Tow Hyattsv: 0, and due to the curred at the time, described in the curred at	an sy 2 No 3 1 24b. Were sy med? 22 No 1 2 2 2 No 1 2 2 No 1 2 2 2 2 No 1 2 2 No 1 2 2 2 No 1 2 2 2 2 No 1 2 2 2 No 1 2 2 2 2 2 2 2 2 2	autopsy findings available of completion of cause of security) SCENE fumes from Rural Route Number, aylor St. as stated. ue to the cause(s) mth, Day, Year)
After this certificate has been signed by the atter funeral director, page 2 should be detached for	ledical Certification; To Be Completed by	25. Was case referred to medical examiner? 1X Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigate 3 Suicide 6 Could not 1 determined 29a. Certifler (Check only one) 2X Medical Exe	Hospital: 1 Inpatient 2 ER/C 28a. Date of Injury 28b. Found: Day Year) 28b. Place of Injury - At home, building, etc. (Specify) Found in structory hysicien: To the best of my knowledge miner: On the basis of examination at the structory of	Outpatient 3 DOA Time of 28c. In Windy M 10 A arm, street, factory, office k ge, death occurred at the and/or investigation, in my 29c. Licen (Type, Print)	26. Place of Derther: 4 Nursing Fury at ork? Yes 2 No	24a. Was a autop: perfor 1 Yes ath Check onl or 1 Market 28d. Describe h Inhaled truck 28d. Location (S City or Tow Hyattsv: and due to the coursed at the time, described in the course of the cour	an sy prior to med? 24b. Were sy prior to death of the sy prior to deat	autopsy findings available of completion of cause of security) SCENE fumes from Rural Route Number, aylor St. as stated. ue to the cause(s) mth, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryla		artment of H <i>tificate of I</i>			giene	5 18193
Ė	Physici	an	1. Decedent's Name (First, Middle, Last) Arthur Blaine	Pichardo	C 70		-	2. Date of Dea Month	Day	3. Time of Death /ear // 12/10 P M
	/Medic		4a. Facility Name (If not institution, give si		DI.	4b. City. Town, or	Location of Death	may	17 20 4c. County of	
	Examin		Washington Cou	nty Hospi	tal rs. last birthday)	Hagers	stown	8. Date of Birth	Washir	ngton County
	Funeral Director		214-09-3252	M 2□F 7. Age (<i>m y</i>)		Months Days	Hours Min.	8. Date of Birth (Month, Day May 15	1914	9. Birthplace (State or Foreign Country) Maryland
	and	}	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Maryl f sho	ō	Maryland Washingt	con	Boonsbo	m				1 ☐ Yes 2X No
	28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
	30 ol		8507 Mapleville F	Road		21	713		United S	tates
900	72 hours after death with the Maryland natural, or Itams 23e or 28e-f show Jigal Exer it attrings be notified at	by Funeral	11. Marital Status	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H if Yes, specify Cuba I Yes 2 No	ispanic Origin? (Sp n, Mexican, Puerto Specify:		14. Race Black,	American Indian, White, etc. White
21215-0036	1 within 72 ho piene. r than "natur from Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired ief Clerk	du <i>ring m</i> ost of world)		16b. Kind of Busi	serving Co.
Maryland 2	ba filled Ital Hyg od othe evant,	Be	17. Father's Name (First, Middle, Last)						Maiden Surname	
2	d 2 should ba th and Mental 7 Is marked of treumatic eve	은	George Emory Rich 19a. Informant's Name/Relationship (Typ		10h Mailin	ng Address (Street	Ani	nie Lync	h City of Tourn S	tata Tin Coda)
S			Arthur B. Richards,	·						yland 21742
	s 1 and 2 of Health a item 27 is other treu		20a. Method of Disposition		. Place of Dispo	sition (Name of natory or other place	inlead No.	Date		ity or Town, State
<u></u>	0 0		1 Burial 2 □ Cremation 3 □ Re 14 □ Donation 5 □ Other (Specify)			en Cemete		20, 2005	Hagers	town Maryland
Baltimore,	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service License		22	. Name and Addre	ss of Facility Dou	ıglas A.	Fiery F	uneral Home aryland 21742
			23a. Part1. Enter the disease, or complic	ations that caused the de						Approximate Interval Between
	Physician /Medical		shock, or hear failure. List only on Immediate Cause (Final disease or condition resulting in death)	Pr	reumor					Onset and Death
	Examiner	L	Sequentially list conditions, b.	Due to (or as a cons	gestive	. Hear	t Fail	lurc		
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a confi	s dence or):					
68760,	ificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as a cons	equence of):					
687	ficate p phys s the	edicai	d.							
.O. Box	The taw requires that the death cartificate has been signed by the attending to the assert should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pred 1 Live birth 2 For 4 Pregnant at time of 9 Unknown	etal death 3	Ectopic pregnancy Other (specify)	,		23d. Date Monti	
Δ.	ires that the signed by the detaction	by	Part II. Other significant conditions con-	ributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did to		ute to the cause of death?
Ö	w requir been si should I	etec						24a. Was a		
of Vital Records,	(G LT	Completed						autop: perfor	sy pri med2 de	ere autopsy findings available or to completion of cause of ath? Yes 2 No
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		Oth		th (Check only or		
o		-: To	1 ☐ Yes 2 ☐ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	28a. Date of Injury	ER/Outpatien 28b. Time of	it 3[] DOA	4 Nursing H		ence 6 Other	
	ding h. After fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	Wor	k? Yes 2 □ No		,,	
Division	Hospitel or Attending P 24 hours after death. Funerel Director: After tely filled in by the funera	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe		eet, factory, office		28f. Location (S City or Tow	treet and Number n, State)	or Rural Route Number,
	To the Hospitel or within 24 hours after To the Funerel Director Completely filled in the Funerel Director Completely filled in the Funerel Funerel Director Completely filled in the funerel Funerel	Medical C		ician: To the best of my ler: On the basis of exam and manner stated.						
	To th withir To th comp	Me	29b. Signature and title of certifier	1		29c. Licens	e number	1	29d. Date signed (Month, Day, Year)
	-		I family m	when		1)0	06039	56	05118	8 \ 0 5
-10			FARID MUR	npleted cause of death (I	tem 23a) (Type,	Print) 112	06039 Hager	stown	MD	21740
:	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature	housed				

		_	For State Registrar	State of Marylar		artment of H			giene	05	18194
Dh	i.		1. Decedent's Name (First, Middle, L	ast)		-		2. Date of De. Month	ath Day	Year	3. Time of Death
	ysicia Aedic		ANTOINETTE THE	RESA BAKER R	ITZ			May	11	2005	6:00 P M
	amin		4a. Fecility Name (If not institution, ga	ive street and number)		4b. City, Town, o	or Location of De	eath	4c. Co	unty of Death	
			Casey House Ho			Rockv				ntgome	
	eral			Sex 7. Age (In yrs. 1 ☐ M 2 五 F 74	. last birthday) Yrs.	If Under 1 Year Months Days		lin. (Month, Da	y, Year)	9. Birthp	lace (State or Foreign htry)
Dire	ctor	-	551.36.0858 Usual Residence of Decedent	74	115.			Jan. 2	0, 193	31 Pen	nsylvania
land	32	ı	10a. State 10b. County	10c. C	ity, Town or Lo	ocation				1	0d. Inside City Limits
Mary -f sh	E E	ţo	Maryland Montgo	merv S	ilver S	bring					1⊠Yes 2□No
r 288	to to	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	itry?
h witl		a.	9502 East Light	Drive		2090)3		U.S	. A .	
deat	3	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.			(Specify Yes or No Jerto Rican, etc.)		Race - Americ Black, White,	
or lite	8	골	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☑ No		1 ☐ Yes 2 ☒ No		30.10 7.1104.1, 010.1,		ecity: White	
CL C IS-UUSO filed within 72 hours after death with the Maryland Hygiene. then "natural", or Items 23a or 28a-f show	Exp	d by	3 X Widowed 4 □ Divorced	II Yes, Give Year or Dates:							
72 i	200	Completed	15. Decedent's l (Specify only highest g	Education rade completed)	16a. Deced	dent's Usual Occup kind of work done DO NOT use retire	oation during most of a	working		of Business/Ind	
ZIZ d withiu giene. ar than	22	g	Elementary/Secondary (0-12)	College (1-4or 5+)		Book-keep			Churc		s Catholic
Hygin Hygin	ent, 1	e Co	17. Father's Name (First, Middle, Las	st)		JOOK-Keep		Name (First, Middle,			
yland build be fill Mental Hy arked oth	0	O B	John Baker				Marc	ia Prelo	renzo		
shou Mind M	umat	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street	and Number or	Rural Route Number	er, City or To	wn, State, Zip	Code)
n Wild F and 2 sh alth and 127 Is m	er tra		Suzanne M. Ritz	/Daughter	9502	East Lig	ht Driv	e, Silver	Sprin	ng, MD	20903
es 1.0 of He	g/		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	DRamoval from State	Place of Dispo cemetery, crer	sition (Name of matory or other place	ce) 05/	Date 14/2005	20c. Locati	on - City or To	wn, State
Pag ment ant: t	ury o		* 4 □ Donation 5 □ Other (Spec		erly-Fa	airfax Cr	ematory	14/2005	Fairfa	ax, Vir	ginia
DEMITTIOTE, MISTYISTIC 2.12.13-UU30 permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show	ny inj		21. Signature of Funeral Service Lic	20500	22 H 1	Name and Addre	ss of Facility	ERAL HOME	TNC		
n g0E	a a		Nanany A. 1	Law he		1800 New	Hampshi	re Ave. S	ilver	Spring	MD 20904
	,		23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications that caused the dea y one cause on each line.	th. Do not ent	er the mode of dyir	ng, such as card	diac or respiratory a	rest,		Approximate Interval Between Onset and Death
Pnysic	_		Immediate Cause (Final disease or condition resulting in death)	a Recurrent C	olon Cs	ncer wit	h Brain	Metastas	es.		
/Med Exami			1	Due to (or as a conse	quence of):						
		-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	quence of):						
nted L	ansit	E L	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
exection and	ial-tra	Examiner	resulting in death) Last	Due to (or as a consec	quence of):						
octificate be executed reding physician and	the bur	lical		d							
riffica ng ph	ast	U	IF FEMALE:								
th cer tendin	or use	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnancy	y		23d.	Date of delive	nry Day Year
e death the atten	of ber	Physician/Me	1 Yes 2 No	4□Pregnant at time of o	death 5	Other (specify)				MONTH	Day 16ai
IS, F.C. DOX OR res that the death certification by the attending plant.	letach		Part II. Other significant conditions	contributing to death but not re	culting in the u	nderhing cause gn	en in Part I	23e Did to	abacco use (contribute to th	ne cause of death?
law requires that the as been signed by th	a pe	l by	Tant in Other Significant Contains	contributing to dodar but not re-	Juling in the w	noonying cause giv	ormin arci.		fes 2⊠N		ably 4 □Unknown
ecords faw requires as been sign	should	Completed						-			
e faw		mpi						24a. Was autop		prior to cor death?	psy findings available apletion of cause of
vital nec sician: The law certificate has b	ıral director, page 2		DE Mas assessment to madical					1 ☐ Yes	2 🔀 No	1 ☐ Yes	2 No
OI VILLAI Physician: Trinis certifica	irecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2] ER/Outpatien	nt 3 DOA Oth		Death <i>(Check only o</i>		Other (Core's	
g g ig	erald	\vdash	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injur Wor	ry at	28d. Describe			повртсе
VISION Attending r death.	unj e	atio	1 Natural 5 Pending 2 Accident investigati		Injury		rk? Yes 2 ☐ No				
Atte	by th	ertification;	3 Suicide 6 Could not determine		nome, larm, str	eet, lactory, office		281. Location (S City or Tox		umber or Rura	l Route Number,
tal or	E Pe	Cer		5515113, 516. (5554)							
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After	oletely fil	edical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exe	Physicien: To the best of my kn eminer: On the basis of examin- and manner stated.	owledge, death ation and/or in	n occurred at the tirvestigation, in my o	me, date and pla ppinion, death o	ace, and due to the courred at the time,	cause(s) and date and pla	d manner as st ce, and due to	ated. the cause(s)
To the To the To the	com	Ž	29b. Signature and title of certific	201		29c. Licens	se number		29d. Date si	gned (Month,	Day, Year)
12			CERCE	1/1		170	11218	5	5/1	2/00)
•			30. Name and address of person who			*		,	· ·	1 000) F F
			Charles Harriso	n, MD, 6001 Mu	ncastle	er Mill F	koad, Ro	ockville,	Maryl	and 208	33
Re	Sta gistr			Registrar's Sign	Goal	R. D					

			State of Maryland / Depart State of Maryland / Depart Cert	rtment of Health and Mer tificate of Death	ntal Hygier	2000 18195
	Physicia	an	1. Decedent's Name (First, Middle, Last)		Date of Death Month	3. Time of Death
	/Medic	ai	EDITH STEVENS REES		1AY 19	
	Examin	er	4a. Facility Name (If not institution, give street and number) WALDORF HEALTHCARE	4b. City, Town, or Location of Death WALDORF		4c. County of Death CHARLES
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8.	Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign
	Director		322-28-0008 1□M 2XF 94 Yrs.		JAN.5,1	911 MARYLAND
	land bw		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	ation		10d. Inside City Limits
	Mary a-f ah	ţ	MARYLAND CHARLES WALDOR	F		~1 ☐ Yes 2√√yo
	or 284	Jirec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	s 23e	rail	4140 OLD WASHINGTON ROAD	20602		U.S.A.
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f ahow thit, the Medical Erschinst must be rodified at	Funeral Directo	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? ↑ □ Vever Married 2 □ Married 12. Was Decedent Ever in U.S. Amed Forces? ↑ □ Yes ३००००	as Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rica	Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc.
9	ral', o	by	Mover Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Year or Dates:	☐ Yes 2 🛱 No Specify:		Specify: WHITE
21215-0036	72 ho "natu	Completed	(Specify only highest grade completed) (Give k.	ent's Usual Occupation and of work done during most of working	16b.	. Kind of Business/Industry
12	within ene. than	dmc	Elementary/Secondary (0-12) College (1-4or 5+)	O NOT use retired)		YWCA
	other	Be Co	17. Father's Name (First, Middle, Last)	AGER 18. Mother's Name (Fit	irst, Middle, Maid	
Maryland	should be ind Mental imarked o	To E	HOWARD DALE REES	ELLA GE	ERTRUDE	STEVENS
Nar	12 sho h and 7 is m traum			Address (Street and Number or Rural Ro		
	1 and Health em 27		20a Method of Disposition 20b. Place of Disposi	HICKORY CIRCLE,		ATA, MD 20646 Location - City or Town, State
ē	Pages nent of I int: If its iry or o		1 — Buriai ALICremation 3 — Removal from State	atory or other place) ITIAN CREMATORY	5-20-0)5 AFFYANDDIA WA
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depirtment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-1 ahow any injury or other traumatic event, the Medical Examination in all be notified at angle.		21. Signature of Funeral Service Licensee MOO47 22.	Name and Address of Facility		
<u> </u>	8258		23a. Part1. Enter the disease, or complications that caused the death. Do not enter	AYMOND FUNERAL S		
L,			shock, or heart failure. List only one cause on each me.		\wedge	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	ory EmBi	hsm	FEW DAY
	Examiner		DEED VEIN	In Rom Bosi	2	ten wix
_	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			U
V	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
8760,	ate be executed hysician and the burial-transit	dicai E	d			
9		/ledi	IF FEMALE:			
Вох	ath ce ttendii or use	ian/I	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of delivery Month Day Year
0	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Med	1 Yes No 9 Unknown 9 Unknown	Other (specify)		,
o, O	s that ned by e deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
ğ	w require been sig should b	ted t	Alzenianer DISIANE		1 🗌 Yes	2 No 3 Probably 4 Unknown
Vital Record	a law r has be e 2 sh	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u>a</u>	Physician: The law r this certificate has t and director, page 2 s		or Western dead of		performed	
	/sicial s certi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient	26. Place of Death (Cl 3 DOA Other: 4 M Nursing Home		6 ☐Other (Specify)
n 0	ng Phi ter thi	Ju: T	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury		Describe how in	
Sio	or Attending later death. Director: After in by the funer	catio	2 Accident investigation	M 1 Yes 2 No	1	
Division of	l or At after o Direc J in by	Certification:	4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide	st, factory, office 281.	City or Town, St.	and Number or Rural Route Number, ate)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific; complately filled in by the funeral director,		29a. Certifier (Check only 2 Medicel Examiner: On the basis of examination and/or inve			
	To the Hi within 24 To the Fi complete	Medical	one) and manner stated.	29c. License number		· · · · · · · · · · · · · · · · · · ·
	or with	-	29b. Signature and title of certifier Attending	D 44436	10	Date signed (Month, Day, Year)
•	0		30. Name and Advess of person who completed cause of death (Item 23a) (Type, P	rint)	100	A 20/ 00
			31. Date filed (Month Park Yay) 32. Signature	IUX VYCLAUF	T/1/11) 0000x
#5	Sta Registr	- 20	31. Date filed (Month MAY 3 1 2005 32. Agistrar's Signature	and the same of th		

05-3483 B.K.S DAVID W. RAY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Inpend item#23a, 27, perMF, G844, 6/29/05 IT

		1 - For State Registrar		Siale	JI IVIAL	yland / Dep <i>Ce</i>	artmen <i>rtificat</i>	e of i	Death	and N	nental H	/gien Reg. N	- U U U		18196
Physici	an	1. Decedent's Name (First, I	, .								2. Date of D Month MAY	eath	°2005 *°	ar	3. Time of Death
/Medi Examir	cal	David Wayne 4a. Fecility Name (If not insti			ımber)	· · · · · · · · · · · · · · · · · · ·	4b. City,	Town, or	Location	of Death	MAI	4	c. County of E	eath	
		203 BAPTIST I		Sex	7 4-0 /	In yrs. last birthday	HANC If Under		If Under	24 Hrs	D Data of D		WASHING		
Funeral Director		219 - 68-0181		1 M 2 □ F	7. Age (46 Yrs.	Months	Days	Hours	Min.	8. Date of B (Month, D March 8.	ay, Yea)	Coun	lace (State or Foreig try)
land ow		Usuel Residence of Deceder 10a. State 10b. Co			1	0c. City, Town or L	ocation							10	0d. Inside City Limit
Maryland a-f show	ctor	MD Was	hing	ton		Hancock									1 X Yes 2 □ N
or 28	Director	10e. Street and Number					10f. Zip	Code				10g. C	itizen of Wha	Coun	try?
s 23e		203 Baptis	t Ro		and an Free			750			7 17		USA		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic evant, the Madical Examiner must be notified at ance.	by Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4 Divo		12. Was Dec Armed Fo 1 Tyes If Yes, Gi Year or D	orces? 2 XNo ive	er in U.S.	was Deced If Yes, spec 1 \(\text{Yes}		Ispanic Or in, Mexica Specify:		ecify Yes or N Rican, etc.)	0-	14. Race - A Black, V Specify:	Vhite, 6	
72 hou		15. Dec	edent's E	ducation ade completed)		16a. Dece	dent's Usua kind of wo	al Occup	ation	et of work	ina	16b. I	Kind of Busine		
within ne.	Completed	Elementary/Secondary (0-			(1-4or 5+)	life.	DO NOT u	se retired	i)	or work	mig				
filed v Hygie othar 1		17. Father's Name (First, Mic	idle, Las	")		Carpe	nter		18. Moth	er's Nam	e (First, Middle		ailer / n Sumame)	Asse	embly
uld be Vental rrked o	To Be	Ernest D. Ra	У						Ina	D. 1	Fergesc	n			
2 sho and h is ma	i ji	19a. Informant's Name/Rela									al Route Numi				Code)
1 and Health am 27 thar t		Ernest D. Ray 20a. Method of Disposition	/Fat	her		14645 20b. Place of Dispo	High	Ger	many		d Hanco		D 2175		wn State
Pages ent of nt: If it ry or o		1 XBurial 2 Crema 4 Donation 5 Oth				cemetery, cre	matory`or o	ther plac	´ I						
partm portar y injur		2 Signature of Fire ral Se			i	Buck Vall	Name ar						Fordsb Main St		
88288		23a. Part1. Enter the diseas	7	XX	Mn						P.A. Ha	nco			50-0368
Pnysician /Medical Examiner	_	shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	List only	a Cir Due to b	rhosi (orasa c	is of the consequence of):	Live	r			- 11/-				Interval Between Onset and Death
icate be executed physician and s the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	c		onsequence of):									
death certif e attending od for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1		birth 2 (nant at tim	Fetal death 3	Ectopic pr Other (sp						23d. Date of Month		ry Day Year
law requires that the der as been signed by the a 2 should be detached fo	by	Part II. Other significant cor	ditions	contributing to d	leath but r	not resulting in the u	nderlying c	ause give	en in Part I			tobacco Yes 2	_	e to the	e cause of death?
The ate ha	Completed										1 X Yes	psy ormed? 2 \(\sum \) No	prior death	to com	sy findings available pletion of cause of 2 No
Physician: r this certific ral director.	To Be	25. Was case referred to me examiner? 1 Ves 2 No	alcai	Hospital: 1 🗆	Inpatient	2 ER/Outpatier	it 3∏ DC	Othe			n <i>Check on</i> me 5 ☐ Res		6X Other (S	necify	AT SCENE
or Attanding Phalter death. Diractor: After the in by the funeral		E [100:40:11	estigatio	28a. Date (Mon				8c. Injury Work	-		28d. Describe			poony	
To the Hospital or Attand within 24 hours after deatl To the Funaral Director: completely filled in by the	Certification:		ould not be termined	280. Place	e of Injury ling, etc. (- At home, farm, str Specify)	eet, factory	, office			28f. Location (City or To	Street a	nd Number or e)	Rural	Route Number,
To the Hospital within 24 hours a To the Funaral completely filled	Medical	29a. Certifier 1 Certifier (Check only one)	ifying Pi ical Exa	miner: On the b	e best of no casis of ex oner stated	ny knowledge, deat amination and/or in d.	n occurred vestigation,	at the tim in my op	e, date an inion, dea	d place, th occurr	and due to the ed at the time,	cause(s date an) and manner d place, and o	as sta due to	ited. the cause(s)
To the within To the compl	Me	29b. Signature and title of Ce	rifier	Dix		M	290	O.C	number •M•E			29d. Da	AY 20,	20	0ay, Year) 05
		30. Name and address of pe	son who	0000		h (Itam 23a) (Txea.	PSTRE	ET,	BALTI	IMORE	E, MARYL	AND	21201		
Sta Registr		31. Date filed (Month, Day,)	9ag 1	2005 32. F	egistrar's	Signature	park	/							

			1 - For State Registrar	State of	Maryland / De <i>C</i>	partment of I ertificate of			ene 0 0 5	18197
			1. Decedent's Name (First, Middle	e, Last)				2. Date of Death Month	Day Yeer	3. Time of Death
	Physici /Medic		Patricia An	nn Smith				May 15,		10:48a M
	Examin		4a. Facility Name (If not institution		per)	4b. City, Town,	or Location of Death		4c. County of Dea	
			Laurelwood	Care		Elkto	on		Cecil	
	Funeral		5. Social Security Number		Age (In yrs. last birthda	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Bir	thplace (State or Foreign ountry)
	Director		218-24-4555	1□ M 2□ F	73 Yrs			8. Date of Birth (Month, Day, Y October	3,1931	MD
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Maryl f sho	ğ	MD Ced	ei 1	Elkto	n				1 ☐Yes 2 ☐ No
	28a	Director	10e. Street and Number		DIROC	10f. Zip Code		100	g. Citizen of What Co	ountry?
	3a ol		100 Laure	al Drivo		2192	21		U.S.	Α.
	ms 2	Funerai	11. Marital Status	12. Was Deced	ent Ever in U.S. 1	3. Was Decedent of I	Hispanic Origin? (Spe	ecify Yes or No-	14. Race - Ame	erican Indian,
9	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show is Medical Evar treat must be rediffed at	Ē	1 Never Married 2 Marr	ried Armed Forc 1 ☐ Yes 2 If Yes, Give			san, Mexican, Puerto	Hican, etc.)	Black, Whit	
21215-0036	ours Frail,	d by	3 ☐ Widowed 4 € Divorced	Year or Date	95:	1 ☐ Yes 2√€ No	ареспу.		Specify: Wh	ite
5	72 h natu	Completed		it's Education st grade completed)	(G.	cedent's Usual Occu ve kind of work done	during most of works	ing 16	6b. Kind of Business	/Industry
12	within	mp	Elementary/Secondary (0-12)	College (1-4	lor 5+)	DO NOT use retire	·			_
	iled Hygie Ither		1 2 17. Father's Name (First, Middle,	Last)	Cer	tliled N	Jursing A	ASSÍST. e (First, Middle, Ma	Medic	al
Maryland	d be intal I) Be						e Maslir		
₹	should Me	ဥ	Joseph C		19b. Ma	ilina Address (Stree	and Number or Rura			Zip Code)
Z	nd 2 s lith ar lith ar 27 is 1 rau									. ,
ē,	Hea Hea tem other		Danielle Bla 20a. Method of Disposition	unkensnip,	20b. Place of Dis	position (Name of	112 COM	Date 20	c. Location - City or	Town, State
100	Pages nent of I ant: If its ury or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		ate	rematory or other pla rris, In		17.2005	West C	hester, PA
Baltimore,	그는 판결 .		21. Sit alura of Quarter Service			22. Name and Addre		17/2000	nest c	nester, FA
m	Depa Impo any in		* The				• Gee Fu			
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau	used the death. Do not	miter the mode of dy	ng, Julh as Satdiac a	or reEpilator tapen	, MD 2	1 92 Tximate Interval Between
	Physician		Immediate Cause (Final disease or condition	04	make Para	0 2 0	1.40			Onset and Death
	/Medical		resulting in death)	Due to (or	as a consequence of):	Tacc.	200			
	Examiner		Sequentially list conditions,	b	mondey and	long his	0			
	₽ #	iner	cause. Enter Underlying	Due to (or	as a consequence of):	,				
	ecute and I-tran	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	as a consequence of):	Utres				
8760,	cate be execu physician and the burial-tra	aE			Harrie	1606	4			
387	ficate be executed physician and s the burial-transit	dicai		d	unu	9				
×	certif nding use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnancy				23d. Date of del	livery
Box	death atter	ciar	in the past 12 months?	4□Pregnar	nt at time of death	3 □Ectopic pregnanc 5 □ Other <i>(specify)</i> _	y 		Month	Day Year
o.	The law requires that the death certifi tite has been signed by the attending bage 2 should be detached for use as	Physician/Me	9 □ Unknown	9□ Unknow	'n					
<u>ر</u> ت	s tha	by P	Part II. Other significant condition	ons contributing to dea	th but not resulting in the	underlying cause gr	ven in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
ğ	w require been sig should b		Churc de	Longeline	of Lucler	gour		1 🗆 Yes	2 0 No 3 □ Pr	robably 4 Unknown
၁	law requas been 2 should	Completed						24a. Was an autopsy	24b. Were au	utopsy findings available completion of cause of
č	The law	E O						performe	gal? ∣ death?	2 □ No
ita	Physician: The rthis certificate ral director, pag	Be (25. Was case referred to medica examiner?					(Check only one)		
Ž	hysic his ce	၉	1 ☐ Yes 2 ☐ No.	Hospital: 1 🗆 Ing		ient 3 DOA			ce 6 □Other (Spe	cify)
ū	ing P	i o	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	19	Injury 28b. Time Day Year) Injur	y Wo	rk?	28d. Describe how	injury occurred	
Sic	tend death stor: /	icat	2 Accident investig	not be 200 Place o	f Injury - At home, farm,]Yes 2□No	28f Location (Street	et and Number or Ru	um I Pouto Number
Division of Vital Records,	after after Direction by	Certification;	4 ☐ Homicide determ	building	, etc. (Specify)	street, lactory, office		City or Town, S		dia i rioute reamber,
	spita sours neral		29a. Certifier 1 Certifyir	ng Physician: To the b	est of my knowledge, de	ath occurred at the ti	me, date and place,	and due to the caus	se(s) and manner as	s stated.
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Medical one)	Examiner: On the bas and manne	is of examination and/or	investigation, in my	opinion, death occurr	ed at the time, date	and place, and due	to the cause(s)
	To the withing to the complex	ž	29b. Signature and title of certifie			29c. Licen	se number	29d	. Date signed (Monti	h, Day, Year)
			Im cle	i Wen 1	1D	D0	4823		5/16/21	005
	D		30. Name and address of person	1 10	of death (Item 23a) (Typ	e, Print)	1	C 11C	[]	21021
	Sta	to	31. Date filed (Month, Day, Year)		pistrar's Signature	West of	noch of	210	in Mo	174
	Registr		MAY 1 6	2005	gistrar's Signature	parle				

Amen Fune	ded ite	m ec	tor 05/20/05 Please Type or Print in Black Indelible in	nk. Ensure All	Copies Ar	e Legible.	
			1- For State of Maryland / Department o Certificate of Maryland / Department o	of Death	Reg.	CUU	18198
	Physici		Decedent's Name (First, Middle, Last) Robert Stevenson	2	2. Date of Death Month I May 16,	Day Year 2005	3. Time of Death 2:00 P. M
9	/Medic Examir		4a. Facility Name (If not institution, give street and number) 20009 Church Hill Road	n, or Location of Death Midland		4c. County of Dea	th egany
	Funeral Director		5. Social Security Number 06 1.27 M 2 ☐ F 7. Age (In yrs. last birthday)	ear If Under 24 Hrs. ays Hours Min.	B. Date of Birth (Month, Day, Yea March 26, 193	9. Bin Co 35	thplece (State or Foreign ountry) Maryland
	Maryland e-f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Allegany	Midland			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	h with the 23e or 28	al Director	10e. Street and Number 20009 Church Hill Road	21542	10g.	Citizen of What Co US	ountry? A
036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23e or 28e-f show other treumatic event, the Medical Examinational Description	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates: 13. Was Decedent Fit Yes, Give Year or Dates:	of Hispanic Origin? (Speci Cuban, Mexican, Puerto Ri , No <i>Specify:</i>	ify Yes or No- can, etc.)	14. Race - Ame Black, Whit Specify:	
Baltimore, Maryland 21215-0036	swithin 72 ho liene. r then "natur the Medical	Completed	Flementary/Secondary (0.12) College (1.40r.5+)	one during most of working	16b.	Kind of Business	
land 2	uld be filed Aental Hyg rked other tic event,	To Be C	17. Father's Name (First, Middle, Last) Louis R. Stevenson	18. Mother's Name (First, Middle, Maid Lola La	en Sumame) shbaugh	
, Mary	alth and N			reet and Number or Rural I 09 Church Hill Roa			
imore	permit. Pages 1 a Department of He Importent: If Item eny injury or otho		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 1 □ Command of Disposition (Name of Commentary, Crematory or other) 1 □ Commentary or other 1 □ Commentary or other 1 □ Commentary or other	place) M:	te ay 19, 2005	Location - City or Moscow Mil	· ·
Balt	permit. Depart Import eny inj		1-201	Kenzie Funeral Ho		in St., Lonaco	ning, Md. 21539
	Physician		23a. Part / ∉nter the disease, or complications that caused the death. Do not enter the mode of shock for heer failure. List only one cause on each line. Immediate Cause (Final disease or condition		respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of): Sequentially list conditions,	0			4 months
	xecuted and al-transit	xamine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
8760,	O =	ш	d				
P.O. Box 68760	requires that the death centificate be e seen signed by the attending physician hould be detached for use as the burin	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetel death 4 □ Pregnant at time of death 5 □ Other (specify 9 □ Unknown			23d. Date of del Month	ivery Day Year
	v requires that to been signed by should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause Defects will the significant conditions contributing to death but not resulting in the underlying cause	given in Part I.		o use contribute to	o the cause of death?
Division of Vital Records,	as b	Completed			24a. Was an autopsy performed?	prior to death?	itopsy findings available completion of cause of 2 No
Vita	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death (6 Other: 4 Nursing Home		6 ∏Other (Spec	cifv)
sion of	To the Hospitel or Attending Physicien: The I within 24 burs after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	atlon: T	27. Manner of Death	njury at 286 Work? 1 🗆 Yes 2 🗆 No	d. Describe how in	jury occurred	,)
Divis	itel or Att ars after de rel Direct	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offit building, etc. (Specify)		f. Location (Street City or Town, Sta	ite)	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the 2 Medical Examiner: On the basis of examination and/or investigation, in mand manner stated.	ny opinion, death occurred	at the time, date a	nd place, and due	to the cause(s)
	witi To	~) Jesus	ense number 21244		Sate signed (Month	2005
-	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jesus Tan 10701 New Georges Creek Rom 31. Date filed (Month, Day, Year) 32. Registrar's Signature	of Frustbu	rg Mnr	ylund	21532
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature		-, ,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First_Middle, Last. Dav Year **Physician** 12:45 PM ober 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City, Town or Location of Death Examiner Ritchey Hospice Joseph If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday, 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F Months Hours Min 56 Yrs. 578-64-209 Director Washington Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 28a-1 show other traumatic event, the Madical Examiner must be notified at Baltimore 1-Tes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA ircle 21/36 or items 23a Tersimmon Funerai 12. Was Decedent Ever in U.S. Amed Forces? 1 EVes 2 □ No If Yes, Give 2 - /9 - 68 Year or Dates 2 - /3 - 7/ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☑ Divorced Black Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver Private Industry 2 should be filed within and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Morrison Caymond ပ Department of Health and Importent: If item 27 is ma 19a. Info ant's Name/Relationship (Typ-, Int) or Rural Route Number, City or Town, State, Zip Code) Bonita Kearner Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State -17-2005 CheHenham * 4 ☐ Donation 5 ☐ Other (Specify) 23 Name and Address of Facility 21. Signature of Funeral Service Licensee Service 7 1813 Fotomae Avenue SE. Washington
Do not enter the mode of dying, such as cardiac or respiratory arrest, E. Williams D.L. 20003 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each limit. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): the attending physician Physician/Medicai use as the IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death Probably 1 Tes 2 🗆 No Completed Were autopsy findings available prior to completion of cause of death?

1 No 24a Wasan autopsy 2 🕏 Yes 25. Was case referred to examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? of Death 28d. Describe how injury occurred Certification: Hospital or Attending 1 atural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not re determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 29a, Certifie Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) o the within 2 29c. License number 29d. Date si y ed (Monty, Day, Your 29b. Signature and title

Registrar

State

O.O. Box 68760,	
ital Records, F	
Division of V	

		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	
		State of Maryland / Department of Health and Mental Hygiene	
	•	1 - State Registrar Certificate of Death Reg. No.	0200
9		1. Decedent's Name (First, Middle, Last) 2. Date of Death 3.	Time of Death
Physicia		Oddieline Elvaletta ekinnek	3:00 P M
/Medica			<u></u>
Examine	∍r	Fahrney-Keedy Nursing Home Boonshoro Washington	
Europel			(State or Foreign
Funeral Director	Ì	5. Social Security Number 6. Sex 7. Age (M yrs. last birthday) 1f Under 1 Year 1f Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 210-03-2656 91 Yrs. 91 Yrs. 1f Under 24 Hrs. Nonths Days Hours Min. Aug. 26, 1913 Pennsy1	lvania
		Usual Residence of Decedent	LVania
ylanc	ĺ	10a. State 10b. County 10c. City, Town or Location 10d. Ir	nside City Limits
Mar Mar	ţō	Maryland Washington Boonsboro	∐Yes 2≹No
r 288	Directo	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
3a o	<u>Ξ</u>	8507 Mapleville Road 21713 USA	
ms 2	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American In Black, White, etc.	ndian,
ther of			
G , uls , G	þ	3 ⊠Widowed 4 □ Divorced Specify: Specify: Specify: White	е
2 hc 22 hc 22 hc	ted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working	у
Maria Pin 7	pie	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of working life. DO NOT use retired)	
d will distribute the state of	Completed	12 0 homemaker her own hom	ne
o file	Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
Vald by Ments with a strict a strict a	10	John James Donhiser Teressa Viola Lang	
and land		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code	Θ)
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic avant. It whetical Examinar must be notified at once.		Thomas Venetta - nephew 11914 Wesley Dr., Hagerstown, Maryland 21740)
or He itan		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Sometime of cemetery, crematory or other place)	State
Page nent of		Sunset Mem. Grd. Cem. 5/18/05 Fredericksburg	, Va.
partin Poorts		21. Signature of Funeral Service Ligengee 22. Name and Address of Facility MINNICH FUNERAL HOME	
a gg g g			1740
		23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	proximate rval Between
Physician		Immediate Cause (Final	set and Death
/Medical		disease or condition resulting in death) a. HIN VOSCUNATE CAVAVOLUSION AS Jean Due to (or as a consequence of):	7
Examiner		Sequentially list conditions b. Perusum No.	CV
	ē	Sequentially list conditions, nany, reading to immediate Due to or a a co sequence of):	
'60, be executed sician and burial-transif	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events C.	
60, be executed ician and burial-transif			
	cai		
688 ifficat g phy as th	ed		
Division of Vital Records, P.O. Box 687 or attanding Physician: The law requires that the death certificate after death. Director: After this certificate has been signed by the attending physic in by the funeral director, page 2 should be detached for use as the I	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery	
death	<u>icia</u>	in the past 12 months? 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Yes 2 ☑ No Month Day	Year
at the de by the a	hys	9 ☐ Unknown	
cords, P w requires that been signed to should be deter	by P		use of death?
rds no sign and blu			4 Dinknown
CO w re-	Completed	24a. Was an 24b. Were autopsy fi	indings available
Rec he law e has	E	autopsy prior to completing death?	
on of Vital Reding Physician: The In. After this certificate he funeral director, page	ပိ		No
Sicta sicta sican	0	examiner?	
Phy Pris	⊢ ⊦	The state of the s	
On Iding	ij	1 ⊠Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No	
Attandi death, ctor: A	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Rou	ute Number,
Div after I Dirac	Certification;	4 ☐ Homicide determined building, etc. (Specify) City or Town, State)	
spita nours nara fille			
Division of Vital Records, P.O. Box 687 To the Hospital or Attanding Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the one)	cause(s)
ro th vithin ro th	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day,	Year)
		D52323 5/1814	
_	1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
a 54-\$		DR. Khalid Waseem, 1126 Opal Ct. Hagerstown, Md. 2174	0
Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Registra		MAY 7 17 OCCUPATION	
DHMH 17 Rev 1/200	01	- popular in page 1	

			1 - For Stata Registrar		tate of Ma	ırylan		artment of F				Reg. No.	005	- Section of the sect	8201	
	Physici	an	Decedent's Name (First, Midd	e, Last)	1		SP	ほらをし			2. Date of Do	eath Day		ar _	3. Time of Death	М
3 30	/Medic	al	4a. Facility Name (If not institution	n give stre	at and number		01	4b. City, Town, o		of Death	WAL	40	County of D		16001	VI
,	Examin	er	The Johns H	INDV :	as HAC	Pit	12/	RAIT	MULE	. /	itV	- 40.	None	oatii		
· .	Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. I	ast birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Bi	rth Vanal		Birthpla	ce (State or Forei	gn
	Director		069-32-8032	1 □ M	2[X F	65	Yrs.	Months Days	Hours	Min.	JAN • 2	194, rear)	0 Nev	V Yo	rk	
	pu 🖈		Usual Residence of Decedent 10a. State 10b. County	,		10c Cib	, Town or Lo	ocation						100	. Inside City Limit	te
	shor	'n.												100	1 Yes 2 □ N	
	28a-1	ect	Maryland Mon 10e. Street and Number	tgome:	ry	S	ilver	Spring 10f. Zip Code				10g. Cit	zen of What	Countr	17	
	3e or	ā	11705 Lovejoy	Stre	e t				902		t	_			of Ameri	Lca
	ms 2	Funeral Director	11. Marital Status		Was Decedent 8	ver in U.	S. 13.	Was Decedent of H		igin? (Spe			14. Race - A	mericar	Indian,	
٥	after or Ite	Fu	1 Never Married 2X Mar	ried	Armed Forces? 1 ☐ Yes 2 📉 N If Yes, Give	lo	1	1 Tes, specify Cuba 1 ☐ Yes 2 🛣 No	sn, mexica Specify:		nican, etc.)		Black, W Specify: Wh			
3	within 72 hours after death with the Maryland ene. then "naturel", or Items 23c or 28a-f show the Medical Evalua or mail be rediffed at	d by	3 Widowed 4 Divorce		Year or Dates:											
ភ្ន	"nati	Completed	15. Decede (Specify only highe				(Give	dent's Usual Occup kind of work done DO NOT use retired	durina mos	st of worki	ng	16b. Ki	nd of Busine	ss/Indu	stry	
21215-0036	within ene.	duc	Elementary/Secondary (0-12)		College (1-4or 5 5+	+)		ice Manag	,			Rea	.1 Esta	ate		
0	illed v I Hygie other t	Be C	17. Father's Name (First, Middle	Last)						er's Name	(First, Middle					
a	should be filed withir in Mental Hygiene. marked other then matic event, the Mental in Mental in Mental in Mental in Mental in Mental in Mental in Mental in Mental in Mental in Mental in Mental in Mental in Mental in Men	To B	Maurice Scko	1					S	tella	a Fasto	w				
Maryland	2 should and Men Is marke aumatic		19a. Informant's Name/Relation		,			ng Address (Street								
	and 2		Sidney Spiegel	- Hu	sband 	1		Lovejoy								
9	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar cardinent of Heatih and Mental Hygiene. ortant: if item 27 is marked other then "naturel; or liems 23s or 28s-f show injury or other traumatic event, its Madical Evalut withing the rodifical at injury or other traumatic.	,	20a. Method of Disposition 1 □XBurial 2 □ Cremation	3 □Rem	oval from State			sition (Name of matory or other plac			ate		cation - City			
	t. Pa rtmen rtant: njury		' 4 □Donation 5 □ Other (Mt.		on Cemet		05/12			lphi,		yland	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra		21. Signature of Funeral Service	Licenses	ربسد مر			Name and Addre Iward Sag 191 Rocky								
	In principal distribution and principal distribu	Examiner	23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C a. 3		a consequence consequence	uence of):	CHAISTA				arrest,		7	pproximate thereal Between onset and Death VEARS	5
F.U. DOX 08/0U,	t the death certific by the attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒No 9 ☐ Unknown Part II. Other significant condit		If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 ☐ Fetal time of de	death 3[eath 5[Ectopic pregnancy Other (specify)			23e. Did		23d. Date of o	D	ay Year	
S.	signed be det	d b	Tan in Other Signmount Sonate	0113 0011111	oung to dodin of	11 1101 1031	atting in the c	ricerrying cause giv	Dirini anti					Probab		m
Records,	w requir been s should	Completed									24a. Was	20	24h Wara	autone	y findings availab	la
ě	The tav ate has page 2	duo		·-							auto perf	psy ormed?	prior	to comp	letion of cause of	
VIII	icien: Th certificate ector, pag	e C	25. Was case referred to medical	ul					26 Place	a of Death	1 ☐ Yes (Check only	2 X No	1 U Y	es 2	□ No	
	S S	O B	examiner? 1 Tes 2 No	Hos	oital:	nt 2 🗆	ER/Outpatie	nt 3□ DOA Oth	0.0		ne 5 ☐ Res		5 □Other (S	pecify)		
DIVISION OF	ding Ph h. After th funeral	atlon; T	27. Manner of Death 1 Natural 5 ☐ Pendi		28a. Date of Injur (Month, Day	v	28b. Time of Injury	f 28c. Injur Wor	v at	2	28d. Describe			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
DIVIS	el or Attending s after death. el Director: After ed in by the funer	Certification	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten		28e. Place of Injubul			reet, factory, office		2	28f. Location City or To			Rural P	loute Number,	
	To the Hospitel or Atten within 24 hours after deat ⊈o the Funerel Director: completely filled in by the	edical	29a. Certifier 1 Certifyi (Check only 2 Medica	ng Physici Examiner	an: To the best of On the basis of and manner sta	examinal	wledge, deat tion and/or in	h occurred at the tir vestigation, in my o	ne, date ar pinion, dea	nd place, a ath occurre	and due to the ed at the time,	cause(s) date and	and manner place, and c	as state	ed. le cause(s)	
	a di di	Σ	29b. Signature and title of certific	er .	(This	_		29c. Licens					e signed (Mo			
	6		Miller	NA VI	Hore	71	1/2)	SEE) - 0	00		Mb	11 %	20	005	
			30. Name and address of person	- >10	leted ause of de	eath (Item	23a) (Type,	Print)	m1 ==	E 63	DE ==	T. B	1710	W1-	SE who	10.
7.	Sta	to	31. Date filed (Month, Day, Year		3. Registra	r's Siona	ture 🗸	mill Co	ULF	W 7	WEF	1 0	4-11	1110	NAME OF THE PARTY	10/10
	Registr		MAY 16	2005	Blene	, J	GOA	Print)								

			For State Registrar	State of Mary		epartment of F			iene 005	18202
			Decedent's Name (First, Middle, Language)	nst)				2 Date of Death	h	3. Time of Death
	Physici /Medic		EDWARD	ST.CLAI	R	STIFLER	}	Month	Day, EVA	65 6:30 AM
	Examin		4a. Facility Name (If not institution, gi Saint Joseph	we street and number) Medical C	enter	4b. City, Town, o	TOWS	on	4c. County of D	eath ltimore
	Funeral Director		216-12-5528	A STALL OF THE	n yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 2/11/	Year) 9. E	Birthplace (State or Foreign Country) Maryland
	and ow		Usual Residence of Decedent 10a. State 10b. County	10	Dc. City, Town o	or Location				10d. Inside City Limits
	Mary I sho	tor	MD. Har	ford			Fallst	on		1 □Yes 2 No
	n the or 28s	lrec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
	23a c	alD	2836 Scarff	Road			21047		United	d States
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. So of them "natural", or Items 23e or 28e-f show event, I'm Madical Evarifier must be notified at event, I'm Madical Evarifier must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:	r in U.S.	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No		ecify Yes or No- Rican, etc.)	14. Race - Al Black, W Specify:	merican Indian, hite, etc. White
2-0	72 ho natur	eted	15. Decedent's 8 (Specify only highest gi		(0	ecedent's Usual Occup Give kind of work done	during most of worki	ina 1	16b. Kind of Busine	ss/Industry
121	within ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	- 1	ife. DO NOT use retire	d)		Daine Ta	namino
42	e filed within al Hygiene. I other than '		17. Father's Name (First, Middle, Las	O		rai	mer 18. Mother's Name		Dairy Fa	arming
Maryland	d d o d o	To Be	Thomas	Edward	St	tifler	Clara		rene	Hess
lary	permit. Pages 1 and 2 should Department of Health and Men Importent: If Item 27 is marke any injury or other treumatic. once.		19a. Informant's Name/Relationship			Mailing Address (Street	and Number or Rura	al Route Number,	City or Town, State	e, Zip Code)
	and sealth m 27		Linda K. Fish			32B Scarf			ton, Md.	
Baltimore,	Pages 1 nent of H ant: If Ite ary or oti		20a. Method of Disposition 1	☐Removal from S <u>ta</u> te	cemetery,	isposition (Name of crematory or other pla	ce)		20c. Location - City	
Him	it. Pa intmer intent: njury		* 4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice	w Bet	Alr	lem. Gard 22. Name and Addre				Maryland
Ba	permit. Departr Importe eny inju		170 Bluck	en Kuth	111	E.G. Kur	e c	rretts	ville, N	Maryland
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the	death. Do no					Approximate
	Enysician :	67 IU	Immediate Cause (Final disease or condition	GANGREN						Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a co	onsequence of)	:				
г	Examiner		Sequentially list conditions.	BILATER						
	ad sit	inei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co			a and acces			
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c. MULTIPL Due to (or as a co		TEM FAILL :	JKE			
8760,	cate be executed obysician and the burial-transit	icalE	· ·	S d						
9	tificat ng phy as th	ledi								
P.O. Box	that the death certificate ed by the attending phys detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	4		23d. Date of of Month	delivery Day Year
	requires that the een signed by th hould be detache	by Pr	Part II. Other significant conditions	contributing to death but n	ot resulting in tl	ne underlying cause giv	ren in Part I.	23e. Did tob	acco use contribute	to the cause of death?
ords	v require been sig should b							1 ☐ Yes	s 2 🗷 No 3 🗍	Probably 4 Unknown
Records,	law as b 2 sl	Completed						24a. Was an autopsy perform	prior t ed? death	autopsy findings available to completion of cause of ?
Vital		a)	25. Was case referred to medical				26. Place of Death	1 Yes 2		es 2 No
ſΖ	Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 Inpatient	2 ER/Outp	atient 3 DOA Oth	05		nce 6 Other (S)	pecify)
on of	Attending Ph r death. sctor: After th by the funeral		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Tim Inju	ıry Wo	y at rk? Yes 2 □ No	28d. Describe how	w injury occurred	
Division	l or Attene after deatl Director: I in by the	Certification:	3 Suicide 6 Could not determined	De Place of Injury	- At home, farm Specify)	, street, factory, office		28f. Location (Str. City or Town,		Rural Route Number,
_	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical Co		hysician: To the best of m miner: On the basis of ex and manner stated	amination and/o					
	ro the	Med	29b. Signature and title of certifier		0	29c. Licens	e number	29	d. Date signed (Mo	onth, Day, Year)
			1 (brunando	(Freat	1	pa	4710	l loc	5-22-0	5.
	nn		30. Name and address of person who	completed cause of death	(Item 23a) (Ty	/pe, Print)				
ď	<i>y</i> U		ARMANDO'A. TRE			OSLER DR	EVE, TOW	SON, MA	ARYLAND	21204
	Sta Registr	. %	31. Date filed (Month, Day, Year) WAY 3 I	2005 32. Paristrar's	Signature	Charles				
				1-92/1-	- 34	700				

		•	For State Registrar		State of I		nd / Depa		t of H	ealth a				_	18203
	Physici /Medic		1. Decedent's Name <i>(Firs</i> A1a	n			Tuo	ker				2. Date of Dea Month May 7	Day 20)05 Year	3. Time of Death 7:25 A M
1	Examin	er	4a. Facility Name (If not in	_		er)				Location of	of Death			County of Dea	
			4556 Kinmou 5. Social Security Number			Ane (In vrs	. last birthday)	Lan If Under		If Under	24 Hrs.	8 Date of Birt	h 10	Prince	George's thplace (State or Foreign
	Funeral Director		234-76-2920 Usual Residence of Dece	1	I ⊠ M 2□F	57	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day August	21	Wel	ch West VA
	land ow			County		10c. Ci	ity, Town or Lo	cation							10d. Inside City Limits
	Mary	ţ	MD Pr	ince (George's	L	anham								1X Yes 2 □ No
	h the	lrec	10e. Street and Number					10f. Zip	Code				10g. Citi	zen of What C	ountry?
	th will	a	4556 Kinmou	nt Roa	ad			2	0706				τ	J.S.A.	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Itams 23s or 28s-f show any Injury or other treumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 3 Widowed 4 D		12. Was Decede Armed Force 1 Tyes 2 lif Yes, Give Year or Date	s? X No		Was Deced f Yes, spec 1 Yes		spanic Ori n, Mexican Specify:		cify Yes or No- Rican, etc.)		14. Race - Am Black, Whi Specify:	
21215-0036	vithin 72 ha ne. han "natu e Medical	Completed	15. D (Specify onl Elementary/Secondary	1	ade completed) College (1-4d	or 5+)		kind of wor DO NOT us	il Occupa rk done d se retired,	rtion fu <i>ring m</i> osi)	t of worki	ng		nd of Business	·
2	iled w lygiel ther ti		17. Father's Name (First,	Middle I ast	<u>5+</u>		TEac	her		19 Mothe	r'e Name	(First, Middle,		ernmen	<u> </u>
Maryland	ould be f Mental H arked of atic ever	To Be	Silas N.	ľucker	Sr.					Vir	gie	Travis			
	alth and 2 should be a should		19a. Informant's Name/R Bernedine T		-							n, Mary			
Baltimore,	Pages 1 anneat of He		20a. Method of Disposition 1 ☐Burial 2 ☐ Crei 1 ☐ Donation 5 ☐	mation 3		10	Place of Dispo cemetery, crer		ne of ther place			ate		cation - City or	
Ħ	nit. Partme orten Injur.		21. Signature Funeral			/ 11	Linc		d Addres		5/14/ y .I.	B. Jenk			laryland 1 Home
B	Depa Impo		1	11	K /							andover			
	Physician		23a. Part1. Enter the disk shock, or heart failu Immediate Cause (Final disease or condition resulting in death)	ease, or com re. List only	one cause on each	ı line.		er the mod	e of dying	g, such as	cardiac o				Approximate Interval Between Onset and Death
	/Medical Examiner			. [as a consec tensi									
	pe is	lner	Sequentially list condition if any, leading to immedia cause. Enter Underlying	ite d	Due to (or	as a consec	quence of):								
	xecute and Il-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	1	c. Due to (or	as a consec	quence of):								
8760,	icate be executed physician and the burial-transit	ical		l	d										
.O. Box 6	the death certifi y the attending iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregrint the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		23c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal	al death 3□]Ectopic pr] Other (sp					2	23d. Date of de Month	livery Day Year
rds, P	es tha gned be de	by	Part II. Other significant	conditions of	contributing to death	n but not res	sulting in the u	nderlying c	ause give	n in Part I.			_		o the cause of death?
Records,	he hii age	Completed										24a. Was autop	sy med?	24b. Were a prior to death?	utopsy findings available completion of cause of
Vital	lcian: T	BeC	25. Was case referred to	medical						26. Place	of Death	(Check only o		10.100	. AE 110
Ť V	S	70	examiner? 1 ☐ Yes 2 聚 No		Hospital: 1 ☐ Inpa	atient 2	ER/Outpatier	it 3 DC	A Othe	ır: 4 🗆 Nu	rsing Hor	ne 5 K Resid	ence 6	S □Other (Spe	ocify)
ion of	ling Attel		27. Manner of Death 1 Natural 5 2 Accident	Pending investigation		njury Day Year)	28b. Time of Injury	M 2	8c. Injury Work		2	28d. Describe h			
Division	a # F	ertification;		Could not b determined	286. Place of	Injury - At h etc. (Speci	nome, farm, str ify)	eet, factory	, office		2	28f. Location (S City or Ton			ural Route Number,
_	To the Hospitel or within 24 hours after To the Funeral Dircompletely filled in	edical C	29a, Certifier (Check only one)	Certifying Ph ledical Exar	nysician: To the be	s of examina	owledge, deatl ation and/or in	occurred vestigation	at the tim , in my op	e, date an inion, dea	d place, a	and due to the o	ause(s) date and	and manner a place, and due	s stated. e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of	certifier	5			290	. License	number			29d. Date	e signed (Moni	th, Day, Year)
			> /	// .	h			D	3106	9		1	iay :	12, 200	5
9	(4)	1	30. Name and address of	ersogwie	completed cause of	of death (Ite	m 23a) (Type,	Print)							
	9		George Bo		D. 1100	Merca	ntile	Lane	Suit	e 135	Lar	go, Mai	ry1aı	nd 2077	4
	Sta Registr		31. Date filed (Month, Da MAY 1	7 200	3 Regi	strar's Sign	ature App						_		

			1- For State of Maryland / Department of Health and No. Certificate of Death	Reg.		18204
	Physicia	an	1. Decedent's Name (First, Middle, Last) Frances Louise Thomas	2. Date of Death Month 15,	2005 Year	3. Time of Death
	/Medic Examin	al	Trances Louise Thomas		4c. County of Deal	4:15 A. ^M
	Examin	er	Anne Arundel Medical Center Annapolis		Anne Arur	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Birt	hplace (State or Foreign
L	Director		246-30-3685 1 M 24 80 Yrs. Usual Residence of Decedent	May 3, 19		h Carolina
	yland 10w		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	e Mar	ctor	Md. Prince Georges Bowie			1XXYes 2 □ No
	with th	Funeral Director	10e. Street and Number 10f. Zip Code		Citizen of What Co	untry?
	ns 234	eral	4520 Rising Lane 20715 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp		USA 14. Race - Ame	nican Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic avant, the Medical Examiner must be notified at once.	by Fun	11. Marital Status 1	Rican, etc.)	Black, White	e, etc.
2-0	72 hor	Completed by	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	ring 16b	. Kind of Business/	Industry
2	vithin ne. han "	mple	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)		. 1	
0 0	filed v Hygie thar t	ပ္ပို	12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, Maid	Own home	
lan	lid be lental rkad o ic ave	To Be		. Minshew	,	
lary	shou and M	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run	al Route Number, Ci	ty or Town, State, 2	Tip Code)
ž,	and in 27 m 27 her tr		Mary Lynn Edger - daughter 12504 Ransom Court, G			
5	ages 1 nt of H : Mita		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)		Location - City or	
Baltimore, Maryland 21215-0036	artme ortant injury			8-05 Sui eall Funei		ar yranu
Ba	Dermi Depa Impo any ir		6512 N.W. Crain Hw	y., Bowie		
H	.// ·		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final	or respiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death) a			> luk
	Examiner		Sequentially list conditions, b.			
	pe tis	iner	if any, leading to immediate cause. Enter Underlying Course United by the first cause.			
	al-trar	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
8760,	ite be ysicie	cal	d			
9	entifica ing ph e as th	Med	IF FEMALE:			
Вох	that the death certifited by the attending of detached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of death 5 Other (specify)		23d. Date of deli Month	very Day Year
P.O.	the de	yslo	1 ☐ Yes 2 No 4☐ Fregnant at time of death 5 ☐ Other (specify)			
	res that signed b	by PI		23e. Did tobacc	o use contribute to	the cause of death?
Records,	w require been si should I	ted	COPD	1/2 Yes	2 No 3 Pro	obably 4 Dunknown
3ec	e law has b	Completed	Atrial tobillation	24a. Was an autopsy performed	prior to d	topsy findings available completion of cause of
Vital	ysician: The is certificate hadirector, page	မ Co		1 ☐ Yes 2 ☐		2 □ No
	ysicia is cert direct	To B	examiner?	me 5 Residence	6 □Other (Spec	rify)
0	두 후 교	Liuo		28d. Describe how in		,
Sio	tandii leath. Ior: A the fu	catle	2 Accident investigation 3 Suicide 6 Could not be			
Division of	● Hospital or Attanding I 24 hours after death. ● Funaral Diractor: After etely filled in by the funer	ertification;	4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide	28f. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
	ospita hours unaral y fillec	OI	1	and due to the cause	(s) and manner as	stated.
	To the Hospital or Attanding within 24 hours after death. To the Funaral Diractor: After completely filled in by the funer	Medical				
	To vit	Σ		29d.	Date signed (Month	, uay, Year)
	(F)	-	30, Name and address of person who completed cause of death (Item 23a) (Type, Print)		1001200	>
-	(5)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Petersen MD AAMC Annage 31. Date filed (Month Day Yoar) 32. Registratis Signature	elis Ma	121401	
	Sta Registra		31. Date filed (Mortin, Day, 1987)			

State of Maryland / Department of Health and Mental Hygiene 1- Registrar Amend #2 per PHYS 5/25/05 Ch Certificate of Death Reg. No. 2. Date of Death 5/15/05 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Charles Joseph Thomas May 14, 2005 12:30 A /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 13410 Baden-Westwood Road Prince George's Brandywine 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Yrs. Months Days Hours Min. (Month, Day, Year)

Agy 30, 1922 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1X M 2□ F **Funeral** Maryland Director 577-22-2397 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State 28a-f show the Medical Exeminer must be notified at 1 ☐ Yes 2 No Directo Maryland Prince George's Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 230 13410 Baden-Westwood Road 20613 USA Funeral 12. Was Decedent Ever in U.S. Agmed Forces? 1/∑Yes 2 □ No If Yes, Give Year or Dates: 1942-45 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-tl Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items Bleck, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced White natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within al Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) PG County Public Works Truck Driver 8 permit. Peges 1 and 2 should be file Department of Health and Mental Hy important: If item 27 is marked othe any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Arthur Thomas Mary Elizabeth Windsor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Malinda Kay Baden - Daughter 19811 Aquasco Road, Aquasco, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Maryland Veterans Cem 5-24-05 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Lice see 22. Name and Address of Facility
Huntt Funeral Home
P. O. Box 156, Waldorf, MD 20604 M00053 M ou 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** coronam resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of, Examiner the death certificate be executed tran and Due to (or as a consequence of): attending physicien ar I for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by cerebro Vasculor 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier D46478 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patel, 50 Post Office Road, #304, Waldorf, MD 20602 Dr. Suresh A. 31. Date filed (Month, Day, Year) 32. Rapistrar's Signature State Registrar MAY 1 7 2005

	_		1 - For State of Maryland		artment of Hetificate of L		d Menta	al Hygie Reg.	Ene W	5	18206
	Physici	an	Decedent's Name (First, Middle, Last)				Mo		Day	Year	3. Time of Death
	/Medic Examir		Agnes Tuch 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of D		7 10, 2	2005 4c. County	of Death	12:25 A ^M
	Examin	ler	11909 Falls Road		Potomac					gomer	У
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la.		If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Da	te of Birth onth, Day, Ye			place (State or Foreign
Ш	Director		214-92-2982 ^{1□M 2} ♥F 62	Yrs.			11,	09/19	42	Aust	
	land bw		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Lo	cation					1	0d. Inside City Limits
	Mary Interest	tor	MD Montgomery Pot	omac							1 ☐ Yes 2 🖾 No
	th the	Director	10e. Street and Number		10f. Zip Code			10g.	Citizen of	What Cour	ntry?
	ath wi	ral	11909 Falls Road		20854				Austr		
	er de	Funeral	11. Marital Status 1. Mas Decedent Ever in U.S Armed Forces? 1. Never Married 2. Married 1. → Yes 2. No	. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin n, Mexican, P	? (Specify Ye uerto Rican,	etc.)		ce - Americ ck, White,	
936	urs aft	by	1 ☐ Never Married 2 🖾 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:	1	☐ Yes 2X No	Specify:			Specif	v: Whi	te
2	be filed within 72 hours after death with the Maryland hal Hygiene. ad other then "naturel", or items 23e or 28a-f show event, the Medical Exerciter mast te notified at	Completed	15. Decedent's Education (Specify only highest grade completed)		lent's Usual Occupa kind of work done d		f working	16b	. Kind of B	usiness/In	dustry
2	ne.	mple	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	OO NOT use retired)	27.11.1g 11.100t 07	wog				
N D	filed v Hygie ther t int, in		17. Father's Name (First, Middle, Last)	Homen		18. Mother's	Name (First.	Middle, Maid	Own H		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23e or 28a-1 show entering the propertiest of the renantic event, the Medical Examinet must be notified at ODGs.	To Be	Rudolf Zoechling				Fuehi		3011 0011101		
ary	shou and M s mar	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a	nd Number o	r Rural Route	Number, Ci	ty or Town,	State, Zip	Code)
	and 2 ealth m 27 I		Robert D. Tuch, Husband		Falls Ro						
Baltimore,	Pages 1 nent of H ant: If itel ury or oth		I Ponial 5 Moleniation 2 Puelling and light 2 rate		sition (Name of natory or other place		Date / 1 2 / 2 0		. Location -		
Ħ	it. Pa irtmen ritant: njury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funda Service License		itan Crem . Name and Address	1	/13/20			ırıa,	Virginia
Ba	permit Depar Impor eny in		2 Superior Management of the Control				-	le Tri Rockvi		Marv1	and 20852
			23a. Palt1. Enter the disease or complications that caused the death, shock, or heart failure. List only one cause on each line.						-		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	COMA	of The u	ter	15				Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a conseque	nce of):	,						
1	1. 1.3	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a conseque	nce of):						-	
	d d ansit	Examiner	Cause (Disease or injury that initiated events c.								
Ö,	cate be executed obysician and the burial-transit	Exa	resulting in death) Last Due to (or as a conseque	nce of):							
8760	physic the p	dical	d								
9 xo		Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnance	у					23d Da	te of delive	NDV.
m.		Iciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 4 Pregnant at time of dea		Ectopic pregnancy Other (specify)				1	nth	Day Year
J.	at the by the	hys	9 ☐ Unknown								
	The law requires that the te has been signed by the bage 2 should be detache	by	Part II. Other significant conditions contributing to death but not result	ing in the ur	iderlying cause give	n in Part I.	23	le. Did tobaco	2 No		ne cause of death? ably 4 □Unknown
Ö	w requir been si should I	eted					_	-			
He	The law cate has I page 2 s	Completed					_	 a. Was an autopsy performed 	?	prior to cor death?	psy findings available npletion of cause of
Vital Records,		e Co	25. Was case referred to medical			26 Place of	Death (Chec	Yes 2	No	1 🗌 Yes	2 No
	ysicien: nis certifica director, p	To B	examiner?	R/Outpatient				Aesidence	6 □Oth	er (Specify	1)
0	ding Phy h. After thi funeral		27. Mann Death 28a. Date of Injury 2 1 atural 5 Pending (Month, Day Year)	8b. Time of Injury	28c. Injury Work	at		escribe how in			
20	Attendi death. ctor: A y the fu	catl	2 Accident investigation	- 1-		es 2 🗆 No	004 1 -	(Ct			
Division of	or Attendater death Director:	Certification;	4 Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	ie, iarm, stre	евт, тастогу, оптсе		Cit	y or Town, Si	tate)	er or Hura	l Route Number,
	spite hours nerel / filled		29a. Certifier 1 ertifying Physician: To the best of my knowl	edge, death	occurred at the time	e, date and p	lace, and due	to the cause	e(s) and ma	inner as st	ated.
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director,	edical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	n and/or inv	estigation, in my opi	inion, death o	occurred at th	e time, date	and place,	and due to	the cause(s)
	To T	Σ	29b. Signature and title of certifier	1	29c. License	the second	11221		Date signe	/	Day, Year)
			1 100000 111		MO	VVV	7 336	1	/ [[ا	00	- 100
	10		30. Name and address of person who completed cause of death (Item 2) 2150 Pennsy / vmir Ave Nw	Suite	7rint) 3 - 428	WASh	119 Xm	OC	200	3 7.	
	Sta	te	2150 Pennsylvania Ave NW 3 31. Date filed (Month Pay Year) 3 2005 32. Tegistrar's Signatu	9 1	act 1	3 007	1100		200	- 7	
	Registr	ar	Mill I o 2003 position to	" My	ALL THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO I						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** LESLIE DAVID TONEY MAY 13, 2005 4:17 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign
Country) Months Days Hours 1**X**M 2□ F Yrs. Director 214-86-5848 APR. 29, 1961 WASH. D.C. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is markad othar than "natural", or Itams 23a or 28a-f show othar traumatic evant, the Medical Examinar must be rotified ut 1 Yes 2 □ No Director WV. BERKELEY **MARTINSBURG** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 SPREADING OAK DR. 25401 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No þ Specify: 3 ☐ Widowed 4 Divorced WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 Is markad othar than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 BOOKBINDING PRINTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MARDEN TONEY MERRILL FAYE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is many injury or other traum any injury or other traum ance. MERRILL FAYE WARD/MOTHER 105 SPREADING OAK DR., MARTINSBURG, WV. 25401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 5-17-2005 RIVERDALE, MD. 22. Name and Address of Facility

CHAMBERS FUNERAL HOME & CREMATORIUM, P.A.
5801 CLEVELAND AVE., RIVERDALE, MD. 20737 21. Signature of Funeral Service Life insee leur 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Henothary **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury) Due to (or as a consequence of): Examine The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. the i þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ★ Yes 2 □ No 24a. Was an certificate has b autopsy performed? Division of Vital 2 🗆 No 1 Yes Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: P 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director 6 Could not be determined 3 TSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide in 24 hours. tha Funeral Dire 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 To tha 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0062435 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20874 SAYYAID MI 13219 EXECUTIVE PARK TERR, GERMANTOWN, MD 31. Date filed (Month, Day, Year) Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene

						Ce	rtificate	of	Death	7		Reg.	No.	0 1	() tue 4	
	Di contrata		t's Name (First, Mic	die, Last)							2. Dete of Month		Day	Vana	3. Time of De	eath
	Physicia /Medic		Helen	M. Tong	ue								Day 2005	Year	4:11	ma .
	Examine	4 - 5 - 110		ion, give street and r					4b. City, To	own, or L	ocation of D		4c. County		1 1 1 1	Dit
		Crof	ton Con	valescen	t & Rel	hab. (Cente	r	Crof	ton			Anne	Aru	ndel	
	Funeral		curity Number	6. Sex	7. Age (In yrs.		If Under 1	Year	If Unde	r 24 Hrs.	8. Date of	Birth			lace (State or F	oreign
.0	Director	214-1	2-4079	1 □ M 2 🖾 F	93	Yrs.	Months	Deys	Hours	Min.	Aug.	Day, Ye		Coun Mary		
	ō	Usuel Resid	lenca of Decedent								1					
	how =	10a. Stete	10b. Coun	ty	10c. Cit	ty, Town or Lo	ocation							1	0d. Inside City L	Limits
	Ma	Marv1	and Ann	e Arunde	1 Anr	napol:	is								1 XYes 2	□ No
	r 28		end Number				10f. Zip C	Code				10g.	Citizen of \	Whet Coun	itry?	
	3a o		Washi	ngton St	λnt	201	2	140	11					US	7	
	ins 2	29 W		12. Was De	cedent Ever in U					rigin? (Sp	ecify Yes o	No-	14. Rac	e - Americ		
	ther the	5 1 □ Nev	er Merried 2 Me	Armed	Forces?		Was Decede If Yes, specif	y Cuba	an, Mexica	n, Puèrto	Rican, etc.)			ck, White,		
21215-0020	urs e	3XI Wid	owed 4 □ Divorce	If Yes C	Bive		1 ☐ Yes 2	₩ No	Specify	:			Specify	/: B1	ack	
5-0	72 h	Elementa 1	15. Decede	ent's Education est grede completed	4)	16e. Dece	dent's Usual	Occup done	etion during mos	st of work	ina	16b.	. Kind of B	usiness/Ind	Justry	
2	within lene. than "	Elementa	ry/Secondary (0-12)		(1-4or 5+)	life.	kind of work DO NOT use	retired	1)			l				
2	Hygier Hygier ther th	1	2th	2.	yrs.	Nurs	se					P	riva	te D	uty_	
P	単五名	17. Fether's	Neme (First, Middle	a, Last)					18. Moth	er's Name	e (First, Mia	dle, Maid	len Surnam	ne)	_	
/la	Mentai Mentai mrked o		ed Davis	5					Μi	nni	e Ste	ewar	t			
an	S E E		ant's Name/Reletion	ship (Type, Print)		19b. Maili	ng Address (Street	end Numb	er or Run	el Route Nu	mber, Cit	y or Town,	State, Zip	Code) 2.1	037
Σ	end 2 saith e n 27 is	Rober	t A. To	nque (So	n)	120	Va114	2 T/	View	7 A376	e. Ed	CIETI	ater	. Ma	ryl;an	d
ē,	- T E E		of Disposition		20b. P	Place of Dispo	sition (Name	of		1100	Date		Location -		-	
20	g = 5			3 □Removal from		emetery, crei staate										
Baltimore, Maryland	글 원립을 .		netion 5 Other (Par	'k					5/16/	05	Anna	poli	s, Md.	
Ba	Deem Depe impo	21. Signatur	re or Funeral Servic	a Licansee			2. Name and			•	a Moz			D 3		
Ξ.	40244	To	way H,	Base M	00883	É	Vm. Re 321 We	est	St.	Ant	s Mor lapol	is.	ry, Md	2140	0.1	
		23a. Part1. shock.	Enter the diseese, or heart failure. Lis	or complications that st only one cause on	caused the death	h. Do not ent	er the mode	of dyin	g, such as	cardiac	or respirator	y arrest,	1101		Approximate Interval Betwee	20
1	Physician			,	0.0017 [81.01									I F	Onset and Dear	ith
	/Medical	Immediate (Cause (Final	Co	in alio.	mya	bar	M.	u					1		3
36	Examiner	resulting in		в	Due to /o	. 95 9 00000	manca ot):								Jean.	5
				H 4	Due to (o perten Due to (o en o Scl	5 1/4	0 6	/	101/	~ X1	S. Ore	211	C Dag.		1-000	0
	uted d ensi	Caarranian	. link non-diking	P b. 3 19	Duntala	7 3 1 0-	uonno of	C	1000		Men	DI	3+00,	~	Jron	<u> </u>
Ć.	certificate be executed rding physician end use as the buriel-trensit	if eny, leedir	r list conditions, ng to immediate er Undertying	1 00	Coll	05 0 0011500	delice oi).	. 1		00.	1	* .	0			
92	sicia b bur	Ceuse (Dise	ease or injury	C O. FITA	6/03CK+	enone	· Un	CW/	10 Va	JJCU	uan	DIS	cas	~ >	1 cm	Š.,
68760,	certificate be iding physicia ise es the bur	resulting in o	death) Last		Due to (or	r as e conseq	uence ot):									
X	centi Iding Ise e			d												
m																
o	the dr	Part II. Other	significant condit	ions contributing to	death but not resu	ulting in the u	nderlying cau	se give	en in Part I	l.	23b. D	id tobac	co use cor	tribute to	the cause of de	eath?
۵.	d by detec	TO:	abete	& MI	ollitu	2					1	☐ Yes	2 X No	3 ☐ Prob	ably 4 ☐ Uni	known
Ś	res ti signe be d				- 11 (700.											
5	v requires that the death been signed by the etter should be deteched for u	Chi) incon	Ano	m ica							as en au		24b. We ava	re autopsy findir ilable prior to	ngs
ပ္ထ	aw r	/ 5	COMIC	1110	11.101										npletion of caus leath?	ө
ř	The law requires thet the death cete has been signed by the etter page 2 should be deteched for the cete.										11	☐ Yes	2 No	1□	Yes 2□No	
<u>ta</u>	clan: 'entifice	25. Was cas	e referred to medica	al					26 Place	of Death	(Check on		^			
Division of Vital Records, P.	Attending Physician: or death. ector: After this certific by the funerel director,	examiner 1 ☐ Yes		Hospital:	Inpatient 2	ER/Outpatien	t 3□ DOA	Othe			me 5□R		6 🗆 Oth	e (Cassibi	1	
5	Phy erel	27. Manner o	of Deeth	28e. Dete	of Injury	28b. Time of		. Injury Work			28d. Descrit					
6	tal or Attending Pris of the death. al Director: After the in by the funere	1. Natu 2 ☐ Acci		ng (Mor igation	nth, Dey Yeer)	Injury	М		(? Yes 2 🔲							
S	deal deal ctor: y the	3 ☐ Suic	ide 6 ☐ Could	not be	a of Injury - At ho	me farm str	eet factory o				28f Location	Street	end Numbi	er or Rural	Route Number,	
≥ `	or A	4 ☐ Hom	nicide determ	nined 289. Plec	ling, etc. (Specify	<i>')</i>	oot, ractory, c	,,,,,			City or	Town, Ste	ete)	or ribrar	riodio ridiliper,	
	eral illed		i of course	Dharlet T. II	. 1	W. A				, .						
	n 24 hound no 24 hound no Funer pletely fil	29a. Certifier	only 2 Medica	ng Physician: To the Examiner: On the b	oesis of examinat	wledge, deeth ion end/or inv	occurred at estigation, in	the tim	ie, date en pinion, dea	d plece, a th occurre	and due to ti ed at the tim	ne ceuse le, date a	(s) and mai nd place, a	nner as ste	ited. the cause(s)	
	To the Hospital or Attending Physician: The law within 24 hours efter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		re and title of certific	eno mar	nner stated.											
	S S With	29b. Signatu	re and the of certific	11		MN	29C. L		number	- 1	0	29d. L	ate signed	(Month, D	ey, Year)	
		1	Kalke	sh an	0/14	1-11		L) 2	010	28	-	ווכ	1103	>	
		30. Name en	d eddress of persor	who completed cau	se of deeth (Item)	23e) (Type, I	Print)	,	-1		0			.)	07/5	
		DR. A	ROR'A	14300	Galle	ant	FOX L	a	Ste	55.	2 0	0601	12/1	10.1	07/5	
3	State	31. Date filed	(Month, Can Year	32.	Registrer's Signet	ture	•									
	Registrar			3 2005	Selection .	de	1									
DHM	IH 16 Rev 6/95				44	A	ment	8								
							1-75									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Year 0930 M cane-May 15 2005 /Medical TOF 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 59/15/11 Medica NICOMICO Regional eninsu/a If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 N F Months Hours 24-4702 218 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ns 23a or 28e-f shov 1 ☐ Yes 2 No Be Completed by Funeral Director ui + la10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 2 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race American Indian Pages 1 and 2 should be filed within 72 hours after de ment of Heatth and Mental Hygiene. and tem 27 is marked other than "netural", or item ury or other traumatic event, it a Madical Examined. Black, White, etc. ☐Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 4 Divorced 3 Widowed Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) h grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harola 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) truitland 20b. Place of Disposition Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or once. 4 □ Decation 5 □ Other (Specify) -20 ca 21. Signatur of Funeral Service License 22. Name and Address of Facility Bevuice Smith Fo MYDO POCONOKO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ASEVA /Medical Due to (or as a consequence of): **Examiner** FAILURE ENAL Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit CONGESTIVE Due to (or as a consequence of): Box 68760. use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 90 3 ☐ Probably 4 🗓 ⊌nknown 1 ☐ Yes 2 ☐ No Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 100 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Certification; To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) s after death.

I Director: After this d in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled 29a. Certifier Medical

Division of Vital Records, P.O. within 24 hours a To the Funerel (To the Hospital

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5795 105

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

106 Milford ST # 50 4B, Selisbury MD

31. Date filed (Month, Day, Year) MAY 17 State Registrar

32. Signature

		•	For State Registrar	State of Mary			of Health a of Death		al Hygiene Reg. No.	CUU	18210
	. ;		1. Decedent's Name (First, Middle, Last)					Mo	te of Death onth Day	Year	3. Time of Death
	Physicia /Medic	_	Zita Verney					May			
	Examin		4a. Fecility Name (If not institution, give s		ington	Rocks	vn, or Location o	of Death	1	County of Dea	
			Hebrew Home of G1 5. Social Security Number 6. Sex		yrs. last birthday)			24 Hrs. 8. Da			rthplace (State or Foreign
н	Funeral Director			M 2 F	88 Yrs.	Months D	ays Hours	Min. May	te of Birth onth Day, Year) 7 9, 191	7 Au	istria
			Usual Residence of Decedent	140	St. T.			<u> </u>	-		10d. Inside City Limits
	arylar show	7.	10a. State 10b. County Maryland Montgome		c. City, Town or Lo Rockvill						Y□Yes 2□No
	the M	Director	10e. Street and Number			10f. Zip Co	de		10g. Citi	zen of What C	
	ath with the Marylan 23a or 28a-f show		6121 Montrose Roa	d		208				. S. A	•
	death ma 2:	Funerai		2 Was Decedent Ever	in U.S. 13.	Was Deceden	t of Hispanic Ori	igin? (Specify Yon, Puerto Rican,	es or No-	14. Race - Am Black, Wh	
9	after or Ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2X			0.0.7		White
5-0036	tied within 72 hours after death with the Maryland Hygiene. Ither than "naturelt, or Itema 23e or 28e-f show ent, It e Madical Evaniner name be notified at	d by	3 N Widowed 4 □ Divorced	Year or Dates:	16a Door	dent's Usual C	Accuration.		16h K	nd of Business	c/ladusta.
5	n 72 i	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	kind of work of DO NOT use r	tone during mos	st of working	100. K	ria di Basiries:	windustry
2121	i with	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Seci	cetary			Vit	ro Labo	oratory
<u>p</u>	A - 0 -	BeC	17. Father's Name (First, Middle, Last)			-			, Middle, Maiden	Sumame)	
<u>ya</u>	2 should be fited and Mental Hygi is marked other aumatic event, I	To	Abraham Zwiebac					ny Grau			
Maryland	2 sho	r i	19a. Informant's Name/Relationship (Type		24200				e Number, City o		
	1 and Health em 27 ither tr		Constance M. Malo 20a. Method of Disposition	ne – Daughi	cer_ 6960 20b. Place of Disponentery, cre	Belle osition (Name	Glade L	ane, Sai	n Diego. 20c. Lo	cation - City o	r Town, State
nor	Pages nent of int: # lb		1 XBurial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	amoval from State !	cemetery, cre King Davi			5/13/0	5 Fall	s Churc	ch, Virginia
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce.	1 3	21. Signature of Funeral Service License						norial C		
Ö	P P P P P P P P P P P P P P P P P P P	ii y	Donald (.)	tottlen	nulb	170 Pa	alerri 11a	Dileo 1	Doolerri 11	-	yland 20852
*			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the	dath. Do not en	ter the mode o	f dying, such as	cardiac or resp	iratory arrest,		Approximate Interval Between Onset and Death
j	Physician		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	TE MY	OCAR	DIAL	IN	FARC	T	Shoot and Doden
*	Medical Examiner		resulting in dealiny	Due to (or as a co	onsequence of):	4	-04-0	ACC .	FROSIS		
4	.82	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	onsequence of):	A	1462	0>66	120313		
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
Ó,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a co	onsequence of):						
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical			<u>. </u>						
9 X	aath certifica attending pla for use as t	/Me	IF FEMALE: 2	3c. If yes, outcome of p	regnancy					23d. Date of de	elivery
Вох	atten d for u	cian	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1☐Live birth 2☐ 4☐Pregnant at tim		□Ectopic pregi □ Other (speci				Month	Day Year
P.O.	that the di ed by the detached	hys	9 Unknown	9 Unknown					1		
	igned be det	by P	Part II. Other significant conditions cor	tributing to death but n			se given in Part	1. 2		V *	to the cause of death? Probably 4 Unknown
ord	w require been si should t	ted	VITSCUL	AR D	E.MEA	171A			1 ☐ Yes 2		
Records,	e law has b je 2 sh	ompieted			· · · · · · · · · · · · · · · · · · ·			2	4a. Was an autopsy performed2	24b. Were a prior to death?	autopsy findings available completion of cause of
	ician: The certificate rector, pag	O	05 W				00 81		Yes 2 No		s 2 No
Vital	sicial s certifirecto	o Be	25. Was case referred to medical examiner?	lospital:	2 ER/Outpatie	ent 3 DOA	Other \	e of Death (Cha ursing Home 5	Ck only one) ☐ Residence	6 □Other (Sp	ecify)
of	g Phys er this eral di	H- 1	27. Maryner of Death	28a. Date of Injury (Month, Day Ye	28b. Time		. Injury at Work?	-	escribe how inju		//
sior	death. ctor: After y the funer	atio	Natural 5 Pending investigation		,,-,	М	1 Yes 2				
Division	or Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (3		treet, factory, o	office		ocation (Street ar ity or Town, State		Rural Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier Certifying Phys	sicien: To the best of m	ny knowledge, dea	th occurred at	the time, date a	nd place, and du	ue to the cause(s	and manner a	as stated.
	1 24 h	edical		ner: On the basis of ex and manner stated	amination and/or i						
	To the within 2 To the complet	Me	29b. Signature and title of certifier			-	icense number	- 11		te signed (Mor	nth, Day, Year)
•	1		Dune	cin v),	1)	1008	54	14.7	Y 11,	2005
	*		30, Name and address of person who co			, Print)	12.1.	54 SE 121	R	120111	5MO 20852
	C+	ate	31. Date filed (Month, Day, Year)	3 Registrar's	Signature	21 (1)	CA 112C	12 121		100 RC	5 720002
	Regist		MAY 16 200	5 Bleson	J. A.	No. of Street,					

			1 - For State Registrar	State of	f Maryla		artment of H rtificate of L		nd Mental I	Hygiene Reg. No.	105	18211		
	Physici /Medi		1. Decedent's Name (First, Middle, La Sybil			Will	iams		2. Date o Month May	13	Year 2005	3. Time of Death 4:40Å		
	Examir	ner	4a. Facility Name (If not institution, giv 2009 Shadow Rock 5. Social Security Number 6. S	Lane		s. last birthday)	4b. City, Town, or Mitche If Under 1 Year		e		orge's			
	Funeral Director			□ M 2 🔀 F	82	Yrs.	Months Days		Nover	f Birth 19 L Day, Year iber 16	Guya	place (State or Foreign intry) na		
	the Marylan 28a-f show notified at	Funeral Director	MD Prince (George's		Mitch	ellville			100 Citize	n of What Cou	10d. Inside City Limits 11 Yes 2 □ No		
	23a or	al Di	2009 Shadowrock I	ane			2072	21		U.S		ardy:		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medicul Exair or trust be netitled at ADGE.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🗷 Widowed 4 ☐ Divorced	12. Was Dece Armed For 1 Yes If Yes, Giv Year or Da	ces? 2 X No e		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin n, Mexican, F Specify:	n? (Specify Yes o Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black			
1215-0	vithin 72 ho ne. han "natu	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	College (1		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	urina most o		6b. Kind of Business/Industry				
Maryland 21215-0036	d be filed wantal Hygie ed other to event, Ill	Be	17. Father's Name (First, Middle, Last, Eustace Clarke	4	+	1	eacher!	18. Mother's			Government Je, Maiden Sumame)			
lary	2 should and Me Is mark Burnstii	T _O	19a. Informant's Name/Relationship (Type, Print)			ng Address (Street a	nd Number	or Rural Route Nu	umber, City or 1				
	1 and Health tern 27 other tr		Colleen Lloyd/Da 20a. Method of Disposition	ughter	20b.	Place of Dispo	sition /Name of		Date Date		, Mary	Land 20721		
Baltimore,	Pages nent of sent: If it		1 Burial 2 Cremation 3 C 4 Donation 5 Dother (Specif	Removal from S		te of H	natory or other place leaven	- 1	/20/05		•	ng,Maryland		
Balt	permit. Departimport Import any Inj		21. Signature of Funeral Service Licer	all			Name and Addres							
	Physician ' /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. TOST MULTI -INFARET DEMENT A Due to (or as a consequence of): OEREBRO NASCULAR DISEASE											
8760,	ficate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a conse	quence of):								
.O. Box 6	The law requires that the death certifica tie has been signed by the attending ph tage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 PNO 9 Unknown Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) Unknown Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) Unknown Unknown Unknown Unknown Unknown 23c. Did tobact Unknown								23d. Date of delivery Month Day Year			
rds, P	w requires that been signed I should be det	þ										pacco use contribute to the cause of death? as 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
Il Records,		Completed							a	utopsy performed?	24b. Were aut prior to co death? 1 Yes	opsy findings available ompletion of cause of		
Vita	rsiclan: Th s certificate lirector, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 100	Hospital:	npatient 2	∃ER/Outpatien	Othe		Death (Check or		Other (Case	(4.)		
Division of	Attending Physiclan: r death. ector: After this certific. by the funeral director,	Certification: T	27. Manne of Death 1 Natural 2 Accident Investigation 3 Suicide 6 Could not by	28a. Date o (Monti		28b. Time of Injury	28c. Injury Work	/ at 28d. Describe how injury occurred						
N N	ospital or Attend hours after death uneral Director: , ly filled in by the f		4 Homicide determined	28e. Place buildin	g, etc. (Spec	ify)	eet, factory, office		City or	Town, State)		al Route Number,		
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medicai	29a. Certifier (Check only one) 1 ☐ Certifying Ph 2 ☐ Medicel Exam 29b. Signature and title of certifier	ysician: To the niner: On the ba and mann	sis of examin	owiedge, death ation and/or inv	occurred at the tim vestigation, in my op	inion, death	place, and due to occurred at the tir	me, date and pl	nd manner as a lace, and due to signed (Month)	to the cause(s)		
	E358		Franci G	14.995	Ly	Men ky	2	2807	-9	Ma	4 13	2005		
2	(3)		30. Name and address of person who is	LTS UL	110	DY	rinti)	BEU	BULLE	, MD	207	04		
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 7 200	-	gistrar's Sign		de							

			T = For State Registrar	State	of Maryla		artment of F rtificate of		d Menta	Hygien Reg. N	.UUJ	18212		
	Dhomini		1. Decedent's Name (First, Middle,	, Last)					2. Date Mon	of Death	av Year	3. Time of Death		
	Physicia /Medic		Li	inda Elan	a Ward				May		9:25 a M			
	Examin		4a. Facility Name (If not institution,	give street and no	ımber)		4b. City, Town, o	r Location of D	Death	4	c. County of Dea	ath		
			Union Hospital				W115-1	Elkton		1.51		Cecil		
	Funeral		5. Social Security Number 221-36-2178	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs 56	. last birthday) Yrs.	If Under 1 Year Months Days		Win. 8. Date (Mor Sep	of Birth oth, Day, Year t 4,	1948	nthplace (State or Foreign Country) Delaware		
	Director		Usual Residence of Decedent		30				beb	L. 4,	1340	Delaware		
	/land		10a. State 10b. County		10c. C	ity, Town or Lo	cation					10d. Inside City Limits		
	Man P-f eh	to	Maryland C	Cecil			Char	lestown	n			1⊠Yes 2□No		
	h the	Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What C	country?		
	death with the Maryland ims 23a or 28a-f ehow i must be notified at	aD	323 Cecil Aven	iue				21914			U.S.A	•		
	ems ems	Funeral	11. Marital Status	12. Was Dec Armed F	edent Ever in lorces?	J.S. 13.	Was Decedent of H	lispanic Origin an, Mexican, P	? (Specify Yes uerto Rican, e	or No- tc.)	14. Race - Am Black, Wh			
20	s afte	by Fu	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, G			1 ☐ Yes 2 🔀 No	Specify:			Specify:	White		
Ş	hour tural		15. Decedent	Year or I	Jates.	16a, Dece	dent's Usual Occup	ation		16b.	Kind of Busines			
9500-612	in 72 n "na	plet	(Specify only highes	t grade completed		(Give	kind of work done DO NOT use retired	during most of	working	1,550		,		
717	with jiene. r than	Completed	Elementary/Secondary (0-12) Twelve Years	College	(1-4or 5+)		Homema	ker		P	ersonal	Residence		
פ	e filec othe vent,	e e	17. Father's Name (First, Middle, L	.ast)				18. Mother's	Name (First, I	Middle, Maide	n Sumame)			
/land	uld by Menta Menta rrked rrked	To B	Albe	rt Nai					G	ladys	Smith			
Mary	and I s ma		19a. Informant's Name/Relationsh			or Town, State,								
≥	and ealth m 27		James D. Ward	(Husband		Andrew States		., P.O.				wn, MD 21914		
altimore,	or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation	3 □Removal from	State	cemetery, crer	sition (Name of natory or other place	· I	Date		ocation - City o	_		
	tmen tent: tent:		`4 □ Donation 5 □ Other (Sp		R	-	is & Co.,In		5/18/05	wes	t Chester	r, Pennsylvania		
ä	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene "natural", or Items 23a or 28a-f show morphortent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Mcdical Examinar must be notified all once.		21. Signature of Funeral Service L	CONCOR	on sc	Le	Name and Addrese A. Paterryville	terson	& Son Land 2	Funera 1903-0	1 Home, 766	P.A.		
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that only one cause on	each line.	4				itory arrest,		Approximate Interval Between Onset and Death		
	Physician		Immediate Cause (Final disease or condition	a Can	ncer of	breas	Fwitz 1	netasta	asis			475.		
	/Medical Examiner		resulting in death)	Due to	(or as a conse	quence of):	•					•		
		<u>.</u>	Sequentially list conditions,	b Due to	(or as a conse	quence of):								
	led Isit	nlne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	50010	(0) 43 4 001100	q u oneo ory.								
	be execulician and burial-tran	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a conse	quence of):								
8/PU	cate be executed physician and the burial-transit	dicai E		d										
9				,					-					
X Q	w requires that the death certifi been signed by the attending should be detached for use as	clan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou 1□Live			23d. Date of de							
	deat de att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of		Ectopic pregnancy Other (specify)				Month	Day Year		
J.	at the	Physi	9 Unknown			4.5			020	Didtobooo	use sestribute t	thus so the source of death?		
ś	requires that een signed b nould be deta	by	Part II. Other significant condition	ns contributing to	death but not re	sulting in the ui	nderlying cause giv	en in Part I.	238		d tobacco use contribute to the cause of death? ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unkno			
Hecord	een s	ompleted							-	50 for				
e c	2 28	nple							24 <i>a</i>	. Was an autopsy performed?	24b. Were a prior to death?	utopsy findings available completion of cause of		
	Th ate pag	Co							10	Yes 22N				
VITA	Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	/	7.7.0	Oth	05	Death (Check		- 500 /6			
0	ding Phys After this funeral di	: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date	Inpatient 2E	28b. Time of	I 3 DOA	4 Nursi		Residence cribe how inj	6 □Other (Speury occurred	ecity)		
0	ding Ph h. After th funeral	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investig	(Moi	nth, Day Year)	Injury		k? Yes 2 □No						
DIVISION	Atten deal octor	ertification;	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place	e of Injury - At I	nome, farm, str	eet, factory, office					Rural Route Number,		
S	al or after	erti	4 Homicide	build	ding, etc. (Spec	ity)			City	or Town, Sta	ιθ)			
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical C	(Check only 2 Medicel E	xaminer: On the	pasis of examin	ation and/or in	n occurred at the tir vestigation, in my o	pinion, death o	occurred at the	time, date ar	nd place, and du	e to the cause(s)		
	Fo thin Vithin Sompli	Me	29b. Signature and title of certifier	- 44.5			29c. Licens	e number		29d. D	ate signed (Mon	nth, Day, Year)		
	, [0		> Sachder	SMD			100	23322	<u>.</u>		5.	16.05		
	2		29b. Signature and title of certifier Sachdu 30. Name and address of person v S Sachde 31. Date filed (Month, Day, Year) MAY 1 7 2000	who completed cau	ise of death (Ite	m 23a) (Type,	Print) Suite	3B,	Elpto	n ML	21921	1		
	Sta Registr	ite ar	31. Date filed (Month, Day, Year)	5	Registrar's Sign	ature	1							

Linda Elana Ward

		1	_ For	artment of Health and Me	ntal Hygie	2000	18213	
			Decedent's Name (First, Middle, Last)	2	. Date of Death		3. Time of Death	
ı	Physicia /Medic		WILLIAM HALL WILDESEN	1	MAY 22,	2005	10:30 A M	
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death		
			GARRETT COUNTY MEMORIAL HOSPITAL	OAKLAND If Under 1 Year If Under 24 Hrs. 8	Date of Birth	GARRETT	place (State or Foreign	
	Funeral Director		5. Social Security Number 201-20-9732 6. Sex 1 M M 2 T F 7. Age (In yrs. last birthday 87 Yrs.	Months Days Hours Min.	JAN 13,	ear) Cour 1918 MAR	ntry) RYLAND	
	ס		Usual Residence of Decedent					
	arylar show	_	10a. State 10b. County 10c. City, Town or L				10d. Inside City Limits 1 ☐ Yes 2 📆 No	
	he M	Director	MD GARRETT OAKLAN	10f. Zip Code	100	. Citizen of What Cour		
	within 72 hours after death with the Maryland ene. Than "natural", or Items 23e or 28e-f show he Misdiezi Ererili er Livet Le motthed at	١٥	457 KING-WILDESEN ROAD	21550	, og	USA	,	
	death	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Lack Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Ric	ify Yes or No-	14. Race - Americ Black, White,		
9	or ite	y Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No	1 ☐ Yes 2X No Specify:	oan, o.o.,		HITE	
Ö	hours tural,		3 ☐ Widowed 4 🎇 Divorced Year or Dates: 15. Decedent's Education 16a. Dec	edent's Usual Occupation	16	b. Kind of Business/In		
7	n "na	piet	(Specify only highest grade completed) (Giv.	e kind of work done during most of working DO NOT use retired)	7	D. Talle of Desilloss		
212	ad with	Completed	12 FAR			ENERAL FAR	RMING	
Maryland 21215-0036	12 should be filed within "n and Mental Hygiene." F is marked other than "raumatic event, the Mag	Be	17. Father's Name (First, Middle, Last) ISAAC R. WILDESEN	18. Mother's Name (I	First, Middle, Ma NN HALL			
7	hould id Mer marke matic	ပ		City or Town, State, Zip	c Code)			
_				-	A, WV 26			
Baltimore,	permit. Pages 1 and 2 Dep-riment of Health Important: If item 27 any injury or other tra		20a. Method of Disposition 1 Disposition 20b. Place of Disposition 20b. Place of Disposition cametery, creation 3 □ Removal from State	position (Name of Date armatory or other place)	te 20	c. Location - City or To	own, State	
<u>E</u>	Page ment ant: If ury o		`4 ☐ Donation 5 ☐ Other (Specify) OAK GROV	E CEMETERY 5/26/		ORMAN, MAR	YLAND	
Salt	Depert Depert Import any inj once.			22. Name and Address of Facility	P.O. BO		0	
	705 # Q		23a. Part 1. Enter the disease, or complications that caused the death. Do not en	DURST FUNERAL HOME -			Approximate	
	D		shock, or heart failure. List only one cause on each line.		, , , , , , , , , , , , , , , , , , , ,		Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death) Due to (or as a conseduence of):	heart block			3 arrys	
l.	Examiner		Sequentially list conditions h 345tolic X	fent failure			years	
	po is	Iner	Sequentially list conditions, if any, leading to minimize cause. Enter Underlying Cause (Disease or injury	/			LIBARE	
_	and and Il-tran	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):	Leng asease		_	7003	
8760,	cate be executed physician and the burial-transit	dical E	d	7.				
9	tificat ng phy as th	Medi	I STANKE					
Вох	death certific attending pl	lan/N		□Ectopic pregnancy		23d. Date of deliver	ery Day Year	
0.	the a	ysic	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)			•	
Δ.	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Completed by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to t	he cause of death?	
rds,	quires tha in signed I uld be det	d be	dementia, status epileptica	is - temporallook	Yes	2 ☐ No 3 ☐ Prol	bably 4 Unknown	
000	aw requir Is been si 2 should	plet	hand themid, diabetes tope	I	24a. Was an autopsy	24b. Were auto	opsy findings available impletion of cause of	
œ —	The ate has page	Com			performe	d? death? No 1 ☐ Yes		
Vita	ician: Sertific ector,	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (
of	Phys	- To	1 ☐ Yes 2 ☐ No	of 28c. Injury at 28	e 5 ☐ Residend d. Describe how	e 6 □Other (Special injury occurred	fy)	
lon	nding ith. :: Afte e fune	atior	1 ★Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No				
Division of Vital Record	r Attendi er death. rector: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28	f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,	
	ital or A			<u> </u>				
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only one) (Check only one) (Check only one)					
	ro the rother	Me	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month,	Day, Year)	
	. 21.0		Margaret a Kain so	DZ6650		5/22/2	005	
			30. Name and address of person who completed cause of death (Item 23a) (Type	9. Print)	0 11	5/22/2 and Mo	12000	
			31. Date (iled Month, Day, Year) 32. Registrar's Signature	7 garren Highway	Kullle	ma , mo	11550	
	Sta Registi		MAY 2 3 2005	Acart &				

			For State Registrar	State of Ma		d / Depa		ealth an		ntal Hygi	-) 5	18214	
b	Physici	an	Decedent's Name (First, Middle, La Marian Wise	est)			<u>. </u>	-		Date of Death	2005	Year	3. Time of Death 11:59 AM	
	/Medic Examin		4a. Fecility Name (If not institution, given Chestertown Nurse	sing & Reha		tation	If Under 1 Year	sterto	Death DWII Hrs. g	4c. County of Dea				
	Funeral Director			1□ M 2∏F	85	Yrs.	Months Days	Hours	Min. A	(Month Day, prilli,	1920	Cour NY	place (State or Foreign htry)	
36	th the Maryland or 28a-f show o netition at	Director	10a. State 10b. County MD Ken 10e. Street and Number	10f. Zip Code						10	Vhat Cour	0d. Inside City Limits 1 ☐ Yes 2 🔯 No htry?		
	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other then "natural", or Items 23e or 28e-f show imatic event, the Medical Exeminer must be nutified at	by Funeral	202 Calvert Stre 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			Vas Decedent of Hi Yes, specify Cuba		? (Specify uerto Ric	/ Yes or No- an, etc.)		k, White,	merican Indian, hite, etc. White	
Maryland 21215-0036	within 72 hor ane. than "netura he Medical E	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	lent's Usual Occupi kind of work done o DO NOT use retired	ation during most of	usiness/In	ss/Industry							
iand 2	be filed tal Hygi d othar	To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Na							ne (First, Middle, Maiden Surname) Zoe Leibmann				
, Mary	and 2 sho		19a. Informant's Name/Relationship (Laura Drons/Niece			20	g Address <i>(Street a</i> 2 Calvert		et, C	hester	own, l	4D 21	620	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 Is marks any injury or other treumatic.		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special Control of Control o	(y)	Che	metery, cren esapea	sition (Name of natory or other plac ke Cremat	-		2005	oc. Location - Stevens	svill	e, MD	
Ball	permit. Departm Imports any inju		21. Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or con-	Helpha	0							neral rylan	d ^{Home} 21620 ^{P.A}	
E	death certificate be executed Wedical e attending physician and attending physician and for use as the burial-transit	dicai Examiner	shock, or heerf failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or Injury that infitiated events resulting in death) Last	b. Due to (or as	a consequ	ence of):	Scloros						Approximate Interval Batween Onset and Death	
O. Box 68	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)					te of delive	ery Day Year	
rds, P.	quires that n signed by uld be deta	by	M II C II Days and I'm									ribute to the cause of death? 3 Probably 4 Unknown		
Reco	The law requires that the ate has been signed by the page 2 should be detache	Completed	Joint (ontracture 24b. Was an autopsy performed? death										psy findings available mpletion of cause of	
Division of Vital Records,	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry	26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA Other: 41 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Injury M 28c. Injury at Work? M 1 Yes 2 No								
Divis	lel or Atte s after de el Directo ed in by th	Certification:	3 Suicide 6 Could not l		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	To the Hospite within 24 hours To the Funerel completely filled	Medical		hysician: To the best miner: On the basis of and manner st	examinat					at the time, da	te and place,	and due to	o the cause(s)	
l	To t To t	×	29b. Signature and title of contifier	lenk			29c. Licens	e number 0 5 8 8	24	29	d. Date signe	a (Month,	Dey, Year)	
			PAUL DONCH	r 119	CI.	nain	Print) S+	6910	na	MO	21	63	5	
	Sta Regist		31. Date filed (Month, Pay, Year)	2005 32. egistr	ar's Signat	ure.								

			1- St R	or tate egistrar			State o	of Mai	rylan	-		t of H	ealth a	and M	lental Hy		enn5	•	8215	
	Physici	ian	1. Dec	edent's Name			NICO								2. Date of D Month	eath Da	ay Yea	r	3. Time of Death	
	/Media	cal	MARTHA WAYNES 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea									of Dooth	5		C. County of De		3:35AM			
1	Examir	ner											20	4	Mont		norv			
	Funeral		Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In							last birthday)		1 Year	If Under	24 Hrs.		rth		_	ace (State or Foreign	
	Director		Usual	9-16-7. Residence of D	ecedent	10	M 2(X)F		93	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, Year) Sep. 5, 1911				Wash., DC	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examinar must be redified at ance.	by Funeral Director	10a. S	octate OC	10b. County				10c. Cit	y, Town or L	ocation	V	Vashi	ngto	n .			10	d. Inside City Limits 1 □XYes 2 □ No	
	with th	Dire	10e. S	treet and Numb							10f. Zip	Code				10g. C	itizen of What			
	s 23a	erai			36 – 3		St., 2. Was Dec			6 12	Was Dass	d==4 =4 1 E	200						States	
40	ter de Item	Fun		arital Status Never Marrie	d 2⊡ Marri		Armed Fo	orces?		.5. 13.	If Yes, spe	cify Cuba	n, Mexicar	gin? (Spe 1, Puerto	cify Yes or N Rican, etc.)	0-	14. Race - Ar Black, W			
21215-0036	hours at turat', or al Exam	ed by	_	Widowed 4	□Divorced		If Yes, Gi Year or D	ive		162 Door	1 Tes		Specify:			165		B1a		
15	in 72 n "nai	Completed		(Specify	5. Decedent	t grade	completed)			(Give	kind of wo DO NOT u	rk done d	luring mos	t of worki	ng	160.1	Kind of Busine	ss/inai	istry	
212	d with	mo:	Elen	nentary/Second 7th	dary (0-12)		College (1-4or 5+))	PBX	K_&_E	Levat	or 0	pera	tor		Pr	iva	ate	
	al Hyg	BeC	17. Fa	ther's Name (F	irst, Middle,	Last)									(First, Middle	, Maide	n Sumame)			
ylaı	Ments Ments arked	2			Roger	Enn	is										ornton		_	
Maryland	alth and 27 is my 27 is my or traum		19a. li	nformant's Nan Edward				on									or Town, State DC 2001		Code)	
Baltimore,	of Head			lethod of Dispo		2 🗆 🗆	mount from	Ctata	20b. P	Place of Disposemetery, cre	osition (Nai	ne of ther place	e)	D	ate	20c. L	ocation - City	or Tow	n, State	
Ĕ	Pag ment ant: t			Donation 5			inoval nom	State	Har	mony N							Landov		MD	
Salt	ermit. Inport Iny inj		21. Si	gnature of Fun	anal Service I	License،	-A-	+		2							ral Hom			
	90 E # 0			Part 1. Enter the	hu 1		Melie	ou	1								h., DC	1		
	Physician /Medical Examiner		Imme diseas	shock, or heart diate are e (F se or condition ing in death)	failure. List	only one	cause on e	Pne	UMO11 conseq	uence of):		is of dying	y, 30011 a3	cardiac	i respiratory e	111031,		1 1	Approximate Interval Between Onset and Death	
		je l	if any	entially list cond	nactinta .	Ь.	Due to			uence of):										
	nd nd transii	Examiner	that in	Enter Underly (Disease or in itiated events		c.				tion										
8760,	cate be executed physician and the burial-transit	icai Ex	resum	ng in death) La	SI		Due to	(or as a	conseq	uence of):										
687	ficate physics the	P				d.														
O. Box	The law requires that the death certificate be executed site has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	ir 1	MALE: Vas decedent point the past 12 m Yes 2 A		23	c. If yes, ou 1□Live t 4□Pregr 9□ Unkn	birth 2 nant at tir	Feta	Ideath 3	⊒Ectopic pi ⊒ Other (sp						23d. Date of o Month		V Day Year	
Δ.	res that signed b be deta	by Pt	Part II.	Other signific	ant conditio	ns cont	ributing to d	leath but	not res	ulting in the u	nderlying o	ause give	n in Part I.		23e. Did	tobacco	use contribute	to the	cause of death?	
ord	w require been sig should b	ted													1 🗆	Yes 2	! ∑ No 3 □	Probal	bly 4 □Unknown	
I Records,	sician: The law r certificate has be irector, page 2 sh	Completed													24a. Was auto perf 1 Yes		prior t death	o com	sy findings available pletion of cause of	
Vital	cian: ertific actor,	Be		as case referre aminer?								To		of Death	(Check only	one)				
of	Physician: this certific ral director,	6		Yes 2 N	0	ПС		patient		ER/Outpatier			4 LI NU				6 □Other (Sp	ecify)		
O	ding After fune	tion	1 2	Natura	5 Pending		28a. Date (Mon	oth, Day	Year)	28b. Time o Injury	M	8c. Injury Work	at ? /es 2 □		28d. Describe	now inju	пу оссилец			
Division	l or Attending after death. Director: After	Certification:	3[☐ Accident ☐ Suicide ☐ Homicide	6 Could r	not be	28e. Place build	e of Injury ling, etc.	/ - At ho (Specify	ome, farm, st				-	28f. Location (City or To	Street a	nd Number or e)	Rural	Route Number,	
	To the Hospitel of Within 24 hours at to the Funeral D completely filled in			Certifier 1	X Certifyin	g Physi	cian: To the	e best of	my kno	wledge, deat	h occurred	at the tim	e, date an	d place, a	and due to the	cause(s	s) and manner	as sta	ted.	
	the H in 24 the Fu	Medicai		one)		CXOININ	and man	ner state	xamına od.	tion and/or in	vestigation	, in my op	oinion, dea	th occurre	ed at the time,	date an	d place, and d	ue to t	he cause(s)	
	To the Vithin 2 To the Complet	≥	29b. S	signature and til	te of certifier	00		. 2/	40	\	290	License		522			ate signed (Mo	_		
,	(4)			row	we H	T	rene	と /	V(L)		ו עניז	00055	J			May 10,	۷(
	De.		30. Na	me and addres								ני ס	041	*****	Condo	M	20010			
	Sta	ite	31. Da	KO te filed (Month,		ان ان		L D (Registrar			етеп	ra.	911	ver	Spring.	עוויו	20910			
	Registr		M/	AY 1 6	2005	L.		10	-											

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

DHMH 17 Rev 1/2001

State Registrar

MAY 1 6 ZUU5

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗋 🛅 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2005 Year **Physician** Grace Ersell Davis Walker May 6. 5:30 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Hospital Center Cheverly Prince Georges If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea June 7, 1 9. Birthplace (State or Foreign 1 □ M 2**K**) F 73 Yrs. Director 166-28-6420 T931 Virginia Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show froumstic event, it e Madical Extending roust be notified at Director Maryland Prince Georges 1 Yes 2 □ No Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2130 Brooks Drive; Apt. 802 20747 Itams 23a United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: **Black** þ Specify: 3 Widowed 4 Divorced naturel Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Prince Georges 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 9th grade Nurse's Aide Hospital Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles ဂ Davis Lucille Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20747 (Son) : If item 27 I or other tre Health Benjamin Joseph Walker, Jr. 2404 Ramblewood Drive; District Heights, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition May 12,2005 Prince Edward County, permit. Pages 1
Department of H.
Important: If iten
any injury or oth 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) Mercy:/ Seat Baptist Church Cemetery; Farmville, Virginia 22. Name and Address of Faculty R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Cancer of Colon 3 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner End Stage Renal Disease 3 to 4 years Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examiner burial-transit The law requires that the death certificate be executed Anemia 3 years that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Rectal Bleeding the IF FEMALE: 981 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. Constipation 1X Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Rectal Pain page 2 autopsy performed? Yes 2X No Division of Vital 1 ☐ Yes 1 Yes 2□ No Hypertension Hospitel or Attending Physicien: director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To 1 ☐ Yes 2X No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. hin 2

To the

Registrar

29b. Signature and title of or

30. Name and writess of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

Samuel W. Alleyne, M.D.; 6001 Landover Road; Suite 8; Cheverly, Maryland 20785

D25766

29d. Date signed (Month, Day, Year)

May 13, 2005

			State Registrar	e of Maryland / i		artment rtificate			and M	Re	g. No.)5	18218
	Physici	an	1. Decedent's Name (First, Middle, Last)	lioma						2. Date of Death Month May	_	2005	3. Time of Death 11:50 A M
	/Medic Examin		Mary L. Wil 4a. Facility Name (If not institution, give street an			4b. City,	Town, or	Location o	f Death	nay	4c. County		11.50 A
	CXAIIIII	CI	3414 Rickey Ave.				${f T}$	emp1e	Hil	.1s	Pı	cince	George's
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bit		If Under Months	1 Year Days	If Under 2 Hours	Min	8. Date of Birth (Month, Day,	Year)	9. Birthp	lace (State or Foreign htry)
	Director		579-20-2462	81	Yrs.					Oct. 2,	1923	Was	h., DC
	yland		10a. State 10b. County	10c. City, Tow	n or Lo	cation						1	0d. Inside City Limits
	e Maria	ctor	Maryland Prince Geor	ge's		Т	emp1	e Hil	lls				1 DXYes 2 □ No
	with th	Directo	10e. Street and Number			10f. Zip	Code	207/	. 0	10	g. Citizen of \		•
	leath	Funerai	3414 Rickey Ave. 11. Marital Status 12. Was	Decedent Ever in U.S.	13. \	Was Deced	ent of His	2074		cifv Yes or No-		nited e - Americ	States
٥	after or Iter	Fun	1 Never Married 2 Married 1 1	ed Forces? ∕es 2∭No s, Give		fYes, <i>s</i> pec 1 ☐ Yes 2		Specify:	, Puerto F	cify Yes or No- Rican, etc.)		ck, White,	etc. ack
9500-612	d within 72 hours after death with the Maryland Jene. r than "naturel", or items 23s or 28s-f show The Mazical Exacilizations the ricuffied at	d by	3 Widowed 4 Divorced Year	or Dates:							Specify		
2	e filed within 72 h al Hygiene. I other than "natu vent, Ire Madica	Completed	15. Decedent's Education (Specify only highest grade comple	oted)	(Give	dent's Usua kind of wor DO NOT us	k done di	urina most	of working	ng 1	6b. Kind of B	usiness/l <i>n</i>	dustry
7 7	d with giene.	mo	Elementary/Secondary (0-12) Collection 12th	oge (1-4or 5+)	Soci	al Se	curi	ty Ac	lmini	stratio	n.	Gov	ernment
מ	be filed ital Hyg id other event,	Be	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle, M		ne)	
Maryland	d Menidinarke	2	Louis H. Adam		. Maille		(Ctrant a		a a a Our	Ruby]		C4-4- 7:-	Cartal
Z Z	nd 2 sh lth and 27 is r r traur		19a. Informant's Name/Relationship (Type, Print Gregory H. Adams -			-				mple Hi	-		748
Battimore,	es 1 and 2 should be fi of Health and Mental H fitem 27 is marked ot r other traumatic ever		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Removal	20b. Place o	of Dispo	sition (Nam	e of her place)	D.	ate 2	Oc. Location -	City or To	wn, State
Ĕ	ment tant: h		` 4 ☐Donation 5 ☐ Other (Specify)	Ft. I						/2005	Brent		, MD
Pai	permit. Pages 1 and 2 Department of Health s Important: If item 27 li any injury or other tra once.		21. Signature of Prineral Service Licensee	ut, TI	22	4001				N.E. Wa			019
			23a. Part1. Enter the disease, or complications shock or heert failure. List only one cause	hat caused the death. Do on each line.	not ent	er the mode	of dying	, such as	cardiac o	r respiratory arre	st,		Approximate Interval Between Onset and Death
ď	Enysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Pneumonia									Ondot and Dodan
	Examiner			e to (or as a consequence Concestive		art F	a 1 1 11	*0					
	B = 1	ner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	e to (or as a consequence		art r	allu						-
	be executed ician and burial-transit	Examine	that initiated events	Renal Insu		cienc	У	_					
8/60,	ate be executed hysician and the burial-transit	ical E		0.10 (01 43 4 001304461108	Oi).								
٥	certificate nding physise as the	70	0.							-			
X Q Q	death cei ie attendir ad for use	ian/N	in the past 12 months?	s, outcome of pregnancy ive birth 2 Petal death		Ectopic pre					23d. Da Mo	te of delive	ny Day Year
- -	w requires that the death certifica been signed by the attending pt should be detached for use as t	Physician/Me	1 Yes 2 No	Pregnant at time of death Joknown	5_	Other (spe	ecify)						,
7.	s that the ned by the e detache	by Ph	Part II. Other significant conditions contributing	to death but not resulting i	in the ur	nderlying ca	luse give	n in Part I.		23e. Did toba	icco use cont	ribute to th	e cause of death?
cords	requires leen sign hould be									1 🗆 Yes	2 □ No	3 🗌 Prob	ably 4X Unknown
Y Y	The lay ate has page 2	Completed								24a. Was an autopsy perform	1	prior to cor death?	psy findings available inpletion of cause of 2 No
VItal	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?				Othe			(Check only one			
ō	Phys this al di	1: To	27. Mapper of Death 28a. I	1 ☐ Inpatient 2 ☐ EP/Ot Date of Injury 28b.	utpatien Time of		Bc. Injury Work	4 🗀 1901		ne 5 Resider			/)
0	Attending I r death. ector: After by the funer	atio	2 Accident investigation	(Month, Day Year)	lnjury	М		? ′es 2 □ N	No				
DIVISION	Hospitel or Attendi 24 hours after death 5 Funerel Director: 6tely filled in by the f	ertification:		Place of Injury - At home, fa puilding, etc. (Specify)	arm, str	eet, factory	, office		2	8f. Location (Stre City or Town,	et and Numb State)	er or Rura	l Route Number,
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical C	29a. Certifier 1 Certifying Physician: T (Chack only one) 2 Medical Examiner: On and	o the best of my knowledge the basis of examination ar manner stated.	e, death	n occurred a vestigation,	at the time in my op	e, date and inion, deat	d place, a h occurre	nd due to the cau d at the time, dat	ise(s) and ma e and place,	inner as st and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c	License	number		29	d. Date signe	d (Month,	Day, Year)
)	(4)		Sisceres Sans				D	48158			May	12,	2005
	Yg e			M.D. 6192 O	. ,		Rd.	, #50	0, 0:	xon Hill	, MD	20745	5
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature									

State of Maryland / Department of Health and Mental Hygiene UU5 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 7:32 AM **Physician** Wallace Max 2005 neodore /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number Examiner Maryland rince Georges Clinton Southern Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 114M 2□ F June 14. Pennsylvania 199-18-1673 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a State 10b. County If itam 27 Is marked other than "natural", or itams 23a or 28a-1 show or other traumatic evant, the Modical Examiner must be neithfied at 1 Xes 2 No Charles Completed by Funeral Director Md. Waldort 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20601 USA 711 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.
Armed Forces?
1 □ Yes 2 □ No
If Yes, Give /-/6-/946
Year or Dates/-/5-/946 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Federal Government praiser 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fii ment of Health and Mental H ant: If itam 27 Ia marked otl Conway Wallace Theodore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

The Lary Land 2060;

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, State Company or other place) 19a. Informant's Name/Relationship Virginia Wallace 20c. Location - City or Town, State 20a. Wethod of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or once. Henham Vet. Cem. 5-20-2005 ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

23. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Funeral Service Wash., D.C. 20003 Approximate Interval Between Onset and Death Immediate Cause (Final ENOWB M (METASTATIZ K MONTED Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) GRAIN and HTWINS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner sician and e burial-transit The taw requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year ŏ in the past 12 months? 4 Pregnant at time of death 5 Other (specify) the & ☐Yes 2☐No Ó 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Nunknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 2 No certificate 1 Yes of Vital 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 Inpatient 3 100 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ER/Outpatient 3 DOA 0 this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident or Attanding 5 Pending 1 ☐ Yes 2 ☐ No death investigation Diractor: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a 1. sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 02 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IUH 31. Date filed (Month, Day, Y 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** CATHERINE CECILIA WALDMANN MAY 2005 3:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CAROLINE CAROLINE NURSING HOME DENTON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 X F 89 Director 217-09-4129 SEPT. 12, MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location worts ! 10d. Inside City Limits 7 is marked other than "neturel", or items 23a or 28a-f shov treumatic event, the Medical Examinar must be notified at 1 Tyes 2 No Directo MD CAROLINE DENTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22051 BEAVEN DRIVE 21629 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 ☐ Never Married 2 ▼ Married ☐Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE þ Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 PREP CLERK RETAIL SALES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fi h and Mental F 7 Is marked of FREDERICK RUDOLPH WALDMANN KATHERINE KESTLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health ar item 27 ls JOYCE ANN CARLSON/DAUGHTER 2722 HARRINGTON RD., CHESTER, MD 21619 item 20b. Place of Disposition (Name of cemetery, crematory or other of 20a. Method of Disposition 20c. Location - City or Town, State ō <u>=</u> ŏ 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MARYLAND VETERANS CEMETERY permit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 05/16/2005 CROWNSVILLE, MD 21. Signature of Funeral Service License FELLOWS, HELFENBEIN & NEWNAM FUNERAL 106 SHAMROCK RD., CHESTER, MD 21619 HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed that initiated events resulting in death) Last and attending physician a Due to (or as a consequence of) Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) P.O. the year 9 Unknown 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. sign be ementia 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Aortic Stenosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has page 2 s autopsy perform 2 No 1 Yes 2 No 1 Yes Division of Vital Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification; To 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospitel or Attending After 5 Pending Injury s after deu. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funerel I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) D35284 completed cause of death (Item 23a) (Type, Print)

LEN MO 219 S. Washington St Baston mo 21601 ANDREA AUGN MO 31. Date filed (Month, Day, Year) 32. R wrtrar's Signature State 2005 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

1 - For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

18221

	Die		1. Decedent's Name	e (First, Middle, L	ast)					2. Date				3. Ti	ime of Death
	Physic		Sally	Maria W	hite					Month	5 5	Day	Year		525P
	/Medi Examir				ive street and number)		4b	. City. To	own, or Location of D	eath		c. County	of Death		0-01
	LXaiiiii	101	Fahrne	.)	. 0	- 1				outil		Was			0
	Francis		5. Social Security N			6 (In yes) last to	pirthday) If	Under 1	15 DUYD Year If Under 24 F	drs. 9 Date (of Riph			-	State or Fore
	Funeral Director		113-24-0		1□M 2□ X F	72	Yrs. Mc			lin. (Monti	of Birth h, Day, Yea 26,193	33	Cou	ntry) Yor	late or r-ore.
			Usual Residence of			12				pair. 2	20,19	,,	Mew	TOT	K
	filed within 72 hours after death with the Maryland Hydione. Hydione. than "natural", or Itema 23a or 28a-f ehow ant, I're Madical Examiner must be notified at		10a. State	10b. County		10c. City, To	wn or Locatio	on					Τ.	10d. Insi	ide City Limi
	dary	ō	Mđ.	Washi	naton	3.0	רבב ני								Yes 2 📉
	the t	ect	10e. Street and Nur		ing con		iddlet								7
1	the or	늅			_		11	Of. Zip C			10g. C	Citizen of W	Vhat Cou	ntry?	
لو	ath	ra	6410 Zit	tlestown					21769			U.S	S.A		
士	ar de Tem	Funeral Director	11. Marital Status		12. Was Decedent Armed Forces?		13. Was	Deceder s, specify	nt of Hispanic Origin? y Cuban, Mexican, Pu	(Specify Yes of Jerto Rican, etc.)	or No-		e - Americ k, White,		an,
Why -0036	or I			ed 2X Married	1 X Yes 2 □ ! If Yes, Give	53-55		Yes 25					Whi		
Wh 5-0036	ural	d by	3 Widowed		Year or Dates:	JJ JJ						Specify	· M117	LLE	
IC.	72 hours after death with the Marylar "natural", or itema 23s or 28s-1 ehow clical Exartirer must be notified at	Completed	(Spec	15. Decedent's E lify only highest gi	Education rade completed)	16:	 Decedent's (Give kind) 	of work	done during most of	workina	16b.	Kind of Bu	siness/In	dustry	
3 5	ig a g	Id.	Elementary/Seco	ndary (0-12)	College (1-4or 5	5+)	life. DO ∧	VOT use	retired)						
. 6	ed w /gier t, m	ပ္ပ			1		Н	lomen	naker				Home	=	
2 5	al H d oth	Be	17. Father's Name (•					Name (First, Mi					
Maria arvland 2121	of 2 should be filed within 72 hours after death with the Maryla hand before the marked of the marked of the maturel, or fleme 23s or 28s-f ehoy traumatic event, the Modern Examiner must be notified at	2	Peter	r John De	eres				Ade	laide H	lannaa	Clar	:k		
- "	2 sho and and te m		19a. Informant's Na	ame/Relationship	(Type, Print)	19	b. Mailing Ac	ddress (S	Street and Number or	Rural Route N	umber, City	or Town,	State, Zip	Code)	
1/≥	1 and 1 Health em 27 Ither tra		Thornton	F. White	e Jr.	6	410 Zi	ttle	estown Rd.	Middle	town,	Md. 2	21769)	
الم الم	es 1 an of Heal of Heal of Item 2		20a. Method of Disp				of Disposition		of	Date		Location -			ite
				Cremation 3 [5 □ Other (Speci	Removal from State		sburg		i Pici	y 23, 2005			. 1		
Baltim	permit. Pag Department Important: i any Injury o		21. Signature of Fu			Dinin din			Address of Facility			miths			
68	permit. Pag Department Important: i any Injury o		100	2. /	1	0001/1			,	1 II	12525	Brac	dbury	Ave	e.
			23a Part1 Franch	ne disease or con	nplications that caused	the death Do	7 U.L.	Dav	is Funera	I nome	Smith	sburg	Md.		
		_	SHOCK, OF HEAT	it lanure. List only	one cause on each lin	10.	riot enter the	e mode c	or dying, such as card	liac or respirato	ery arrest,			Approx	ximate al Between and Death
	Physician		Immediate Cause (disease or condition resulting in death)	rinai n	a. Me-	nuine	2 COM	r. 01						(1	A ×
	/Medical Examiner		resulting in death)	•	Due to (or as	a consequence	of):								1
	LAUITHIO		Sequentially list con	nditions.	b. Va	whip									CX.
	ם ב	nei	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or i	mediate rlying	Due to (or as	a consequence	of):								1
V	death certificate be executed e attending physician and d for use as the burial-transit	Examiner	that initiated events		C										
o o	an a rial-		resulting in death) L	.ast	Due to (or as	a consequence	of):								
92	te be ysici	cal			d										
89	tifica ig ph as th	led		T											
Box 68760.	eath cerrattendin	7	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome	of pregnancy						23d. Date	of delive	erv	
Ω.	deat d for	cla	in the past 12 i	months?	1□Live birth 4□Pregnant at		h 3∏Ecto 5∏Othe					Mon		Day	Year
P.O	t the	Physician/Medical	9 Unknown		9□ Unknown										
	Physician: The law requires that the de this certificate has been signed by the s al director, page 2 should be detached t	by P	Part II. Other signifi	cant conditions	contributing to death bu	ut not resulting i	in the underly	ying caus	se given in Part I.	23e. D	id tobacco	use contri	bute to th	e cause	of death?
ş	uires n sign	q p								1	☐ Yes 2	2□No :	3 ☐ Prob	ably 4	Unknow
Ö	w requir	Completed								-	· · · · · ·				
ě	e fav has je 2	dm								- a	Vas an utopsy	pr	ere autor ior to con	psy findi npletion	ings available of cause of
=======================================	: The I	ပိ								1 🗆 Ye	erformed? es 2 N	0 1	eath? Yes	2 🗆 No	
/its	yslcian: Th	Be	25. Was case referred examiner?	ed to medical					26. Place of D	eath (Check or					
Ę	Physic this o	P	1 ☐ Yes 2 ☐	No	Hospital: 1 Inpatie	nt 2 ER/O	utpatient 3[□ DQA	Other: 4 Nursing	Home 5 F	Residence	6 Othe	r (Specify	1)	
u u	ding Ph h. After th funeral	:uc	 Manner of Death Matural 	1 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b.	Time of Injury	28c.	Injury at Work?	28d. Descri	be how inju	ıry occurre	d		
. <u>ō</u>	Attending r death. ector: After by the fune	atl	2 Accident	investigatio	n		M		1 ☐ Yes 2 ☐ No						
Division of Vital Records,	or Attenafter deat Director: in by the	tific	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inju	ry - At home, fa	arm, street, fa	actory, o	ffice	28f. Locatio	n (Street a	nd Numbe	r or Rurai	Route I	Number,
Ö	spital or Al ours after o eral Direc filled in by	Certification:			Juliang, etc	· (opecity)				City or	Town, Stat	Θ/			
	e Hospital 24 hours a e Funeral C		29a. Certifier	1 Certifying Pl	nysician: To the best of	of my knowledge	e, death occu	urred at t	the time, date and pla	ce, and due to	the cause(s	s) and man	ner as sta	ated.	
	To the Hos within 24 h To the Fun completely	Medical	(Check only one)	2 ∐ Medical Exer	miner: On the basis of and manner sta	examination ar	nd/or investig	ation, in	my opinion, death oc	curred at the tir	ne, date an	d place, ar	nd due to	the cau	se(s)
	To the I within 2 To the I complet	ž	29b. Signature and t	title of certifier				29c. L	icense number		29d. Da	ate signed	(Month, E	Day Yea	201

State

Registrar

Khalid M. Waseem M.D. 1126 Opal Ct. Hagerstown, Md. 21740 31. Date filed (MMAY 3°1) 2005

30. Name and address of person who completed cause of death (from 23a) (Type, Print)

075352

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment rtificate			and M	ental Hy	giene Reg. No.	005	182	22
ľ	Physic	ian	Decedent's Name (First, Middle, Last)		17177					2. Date of De Month	Day 19	Year	3. Time of	
	/Medi Examir	cal	4a. Facility Name (If not institution, give		re Willien	4b. City, To	own or l	ocation	of Death	May		2005	2245	Рм
	Exami	iei	1395 Blue Ball R				ton	_00411011	, 504(1)			Cecil		
	Funeral		5. Social Security Number 6. Sec	M 2DF	e (In yrs. last birthday,	If Under 1 Months	Year Days	If Under	Min	8. Date of Bir (Month, Da	th ı <i>y</i> , Ye <i>ar)</i>	COUR	lace (State or	
	Director		Usual Residence of Decedent	6	4 Yrs.					FEB 21	, 194	1 Nort	h Caro	lina
	nyland show	_	10a. State 10b. County		10c. City, Town or L	ocation						1	0d. Inside City	y Limits
	he Ma 28a-f s	Director	Maryland Cecil		E1kton								1 🗌 Yes	2 💢 No
	with t		1395 Blue Ball Re	nad		10f. Zip C	.921					en of What Cour ited Sta	•	
	death	Funeral		12. Was Decedent 8	Ever in U.S. 13.			panic Orig	gin? (Spe	cify Yes or No Rican, etc.)		Race - Americ	an Indian,	
36	filed within 72 hours after death with the Maryland Hygiene. thar than "natural", or items 23a or 28a-f show that the Medical Exactiner; ust by rutified at	by Fu	1 Never Married 2 Married	Armed Forces? 1	0 100	1 ☐ Yes 2		, mexican Specify:	, Риепо н	Hican, etc.)		Black, White,	etc.	
Ö	tural'	ed b	3 Widowed 4 Divorced	Year or Dates:	1704	dent's Usual						Whi		
215	d within 72 ho piene. r than *natu	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	(Give	kind of work DO NOT use	done du retired)	ring most	of working	g	TOD, KING	TOT BUSINESSVIR	ustry	
121	e filed withi Il Hygiene. othar thar vant, Ine M		8		Ow.	ner						oofing		
anc	a d o d o d o d o d o d	Be c	17. Father's Name (First, Middle, Last) Raymond Willien				1			(First, Middle,	. Maiden S	итате)		
ary	2 should be and Mental Is marked o	은	19a. Informant's Name/Relationship (Type	pe, Print)	19b. Maili	ng Address (S	Street an		e1 Mo rorRumai		er, City or T	Town, State, Zip	Code)	
Ž,	as 1 and 2 should of Health and Mer itam 27 is marke r other traumatic		Peggy Willien/Wii	fe	1395	B1ue	Ba11	Roa				Land 219		
Baltimore, Maryland 21215-0036			20a. Method of Disposition 1 ☐ Burial 2 【ACremation 3 ☐ R	emoval from State	20b. Place of Dispo cemetery, crea			•	lay 2	3,	20c. Loca West	ition - City or To Chester	wn, State	
Itim		1	4 □ Donation 5 □ Other (Specify)21. Signal re of Funeral Service License	99	R.A. Ferri				005		Penns	sylvania	1	
Ba	permit. Departr Importa any inji		Donald &	. H. a	H H	icks H	ome Stoc	for	Funer	rals, F	kton	, Maryla	nd 210	121
			23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused e cause on each lin	the death. Do not ent	er the mode	of dying,	such as	cardiac or	respiratory a	rest,	, 1.01) 10	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death)	E S	sop ha	geel		(in	cer	No.		Onset and De	eath
	/Medical Examiner		researing in dealing	Due to (or as a	a consequence of):	/								
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury	Due to (or as a	a consequence of):							-		
	ecutec and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last											
8760,	icate be executed physician and s the burial-transit			Due to (or as a	consequence of);									
9	death certificate be executed e attending physician and id for use as the burial-transit	ledical	0		17									
Вох	eath certific attending p	Physician/Me	200. Was decedent program	3c. If yes, outcome o		Ectopic preg	inancv				230	d. Date of deliver	*	
o.	the dea y the at ached fo	ysici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at 1 9☐ Unknown		Other (spec						Month	Day Ye	ar
۵.	es that the de gned by the a be detached	by Ph	Part II. Other significant conditions con	tributing to death bu	t not resulting in the u	nderlying cau	se given	in Part I.		23e. Did to	bacco use	contribute to the	a cause of dea	ath?
Vital Records,	- v -									1 🖼	es 2 🗆 1	No 3 ☐ Proba	ıbly 4 ∏Un	known
ecc	as b	Completed								24a. Was autop		24b. Were autop	sy findings av	railable
a B	The page									perfor 1 Yes	med?	death?	2 U No	
		o Be	25. Was case referred to medical examiner?	ospital:	nt 2 ER/Outpatien		Other:		351	(Check only of				ores I
ס ר	문 등 교	h-	27. Manner of Death	28a. Date of Injury (Month, Day	28b. Time of		. Injury a Work?	4 Nul:		e 5 Resid 3d. Describe h		Other (Specify, ccurred		
Sior	tending leath.	catic	1 Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(World, Day	, oaby Injury	М		s 2 □ N	0					
Division of	or Atten after deatl Diractor: I in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	ry - At home, farm, str (Specify)	eet, factory, o	office		28	If. Location (S City or Tow	treet and N n, State)	lumber or Rural	Route Numbe	er,
_	To the Hospital or Attending within 24 hours after death. To tha Funaral Diractor: After completely filled in by the fune.		29a. Certifier 1 Certifying Physi	ician: To the best of	f my knowledge, death	occurred at 1	the time,	date and	place, ar	nd due to the o	ause(s) an	d manner as sta	ted.	
	To the Ho within 24 To tha Fu completel	ledicai	(Check only 2 Medical Examin	er: On the basis of and manner stat	examination and/or inv	estigation, in	my opin	ion, death	occurre	at the time, o	late and pla	ace, and due to	the cause(s)	
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier	$\overline{}$		29c. L	icense n	umber		2	29d. Date s	igned (Month, P	ay, Year)	
•	141		39-Name and address of person who cor	noleted cause of do	ath (Item 23a) (Tuna	Print) /	100	305	566	149	5	123/		
_	411		Glaria Simons		111 W-	est F	Ha	h 5	7.	Suits	2 30	2 E	IKtor	~ M
	Sta Registr		31. Date filed (Month Pay Year) 200	32 Registrar	's Signature	-	1	•	-		,		at	721
				MOREUS_	I LI LAN	5072 J								

			•	tete of Mandan					•	_	ibic.	
			For State	tate of Maryland					ental Hyg	liene	05	19223
			Registrar		Cer	tificate c	or Deali			eg. Nb.	00	10660
	Physicia	an	Decedent's Name (First, Middle, Last)						Date of Deat Month	n Day	Year	3. Time of Death
	/Medic		GREGORY GERRAR		5	41. Ci. T.			MAY 1	4		3:30 PM
П	Examin	er	4a. Facility Name (If not institution, give stre	et and number)		4b. City, Tow		i oi Death			y of Death	
			505 E. CHARLES S 5. Social Security Number 6. Sex	T. APT. 1 7. Age (In yrs. la	ast birthday)	I.A P.L. If Under 1 Ye		er 24 Hrs.	8. Date of Birth		RLES 9 Birthr	place (State or Foreign
	Funeral Director			2□F 50	Yrs.	Months Da		Min.	(Month, Day, 1AR • 16	Yeer) . 1955		place (State or Foreign htry) RYLAND
			Usual Residence of Decedent					1 1	THIC. I O	71000	I MA	RYLAND
	yland		10a. State 10b. County	10c. City	, Town or Lo	cation						Od. Inside City Limits
	Mar B-f sl	io	MARYLAND CHARLES	Т. А	PLAT	Δ						No 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Cod	le		1	0g. Citizen of	What Cou	ntry?
	d within 72 hours after death with the Maryland jiene than "natural", or tlame 23a or 28a-f show The Maulical Examiner must be nutified at		505 E. CHARLES S	TREET, APT.	1	2064	6			U.S.	Α.	
	eme eme	Funeral		Was Decedent Ever in U.S Armed Forces?	S. 13. V	Vas Decedent	of Hispanic O Cuban, Mexica	rigin? (Specan, Puerto F	cify Yes or No- tican, etc.)		ice - Ameri	
36	s afte	by Fu		1 ☐ Yes 2√C No If Yes, Give		□ Yes 🍇				Speci	fy: D.T.	7 0 17
9500-91212	hours after tural', or ite al Examina		3 Widowed 4 Divorced	Year or Dates:	16a Dassa	ant's Havel On					B.L.	ACK
ç	n 72	Completed	15. Decedent's Educati (Specify only highest grade co	mpleted)	(Give	ent's Usual Oc kind of work do OO NOT use re	cupation ine during mo tired)	st of workin	g	16b. Kind of I	ousiness/in	dustry
7	filed within 72 Hygiene. Ither then "nel	шc	Elementary/Secondary (0-12)	College (1-4or 5+)	MOVE					DATMD	OM M	OVING CO.
	in the	ပိ	17. Father's Name (First, Middle, Last)				18. Moti	her's Name	(First, Middle, I			JVIIVG CO.
Maryland	ld be ental ked c	To Be	HOWARD HEMSLEY				HIL	DERG	ARDE W	INTER	S	
3	should ind Men marke umatic	-	19a. Informant's Name/Relationship (Type,	Print)	19b. Mailin	g Address (Str	eet and Num	ber or Rural	Route Number	, City or Town	, State, Zip	Code)
	d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2		TONYA WINTERS-DA	UGHTER	1271	3 BAR	OAK	DR.,V	VALDOR	F, MD	20	601
Ę.	- I & =		20a. Method of Disposition	20b. PI	ace of Dispos	sition (Name or natory or other	place)	Da	ate	20c. Location	- City or To	own, State
Ĕ	Pages nent of int: If It		1 X Burial 2 ☐ Cremation 3 ☐ Rem `4 ☐ Donation 5 ☐ Other (Specify)	oval from State		EART		5-17-	-2005	LA PL	ATA,	MARYLAND
Baltimore,	permit. Page Department Importent: Il any injury o		21. Signature of Funeral Service Licensee	M00479	22	Name and Ac	Idress of Faci	ility Dat o	SERVIC			
ñ	Per Per Per Per Per Per Per Per Per Per		Muchal O.	1	1.2					646		
			23a. Part1. Enter the disease, or complicat shock, or heart feilure. List only one of	ions that caused the death								Approximate Interval Between
Н	Physician		Immediate Cause (Final disease or condition	-								Onset and Death
	/Medical		resulting in death)	TSchen Due to (or as a consequ	ience of):	Fart		1500	2) *			
Н	Examiner		Sequentially list conditions b									
	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ience of):							
	ecute ind trans	am	Cause (Disease or injury that initiated events c resulting in death) Last									
/60,	be executed sicien and burial-transit		1930King in double cast	Due to (or as a consequ	ience or):							
9/89	w > 0	dical	d							-		
	ding passe as	Me	IF FEMALE:	If yes, outcome of pregnar	nov					024.5	-44-6-	
ROX	atten for us	lan	in the past 12 months?	1 Live birth 2 ☐ Fetal 4 Pregnant at time of de	death 3	Ectopic pregna Other (specify				1	ate of delive lonth	Day Year
o.	requires thet the death certifica leen signed by the attending ph hould be detached for use as th	Physiclan/Med	1 Yes 2 No	9 Unknown	Julii 3	Olliot (Specify	/					
ت <u>.</u>	thet ed by deta	, Ph	Part II. Other significant conditions contrib	outing to death but not resu	ılting in the ur	derlying cause	given in Parl	t I.	23e. Did tot	bacco use cor	ntribute to t	ne cause of death?
ds	uires sign ld be	d by							1 🗆 Ye	es 2□No	3 🗌 Prob	pably 4 hknown
Records,		Completed							24a. Was a	n 24b.	Were auto	psy findings available
	The law ite has b bage 2 s	ЭшС							autops	ned?	death?	mpletion of cause of
Vital		a	25. Was case referred to medical				26. Plac	ce of Death	1 ☐ Yes (Check only on		1 🗆 Yes	2 NO
	Physician: this certific ral director,	To B	examiner? Hosp	oital:	ER/Outpatien	3 □ DOA			e Reside		her (Specil	iv)
o	g Phys er this eral dir		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. I	njury at Work?		8d. Describe ho			,,
<u>o</u>	ndin sth. r: Aft	atlo	Ratural 5 Pending 2 Accident investigation	(Mona, Day 16al)	mjury		1 Yes 2	□No				
Division	To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After toompletely filled in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	et, factory, off	ice	2	8f. Location (St City or Town		ber or Rura	al Route Number,
5	s afte	Cer										
	hour uner uner	edical	29a. Certifier (Check only Certifying Physici Check only Medical Exeminer	an: To the best of my know								
	the H in 24 the F	ledi	one)	and manner stated.								-
	Viit To COU	Σ	29b. Signature and title of certifier	Tagami		29c. Lic	ense numbe	00-		9d. Date sign		
1				Tagam			DS	ンななく	>	5/16/	05	
	4		30. Name and address of person who comp				1	0 1		1		
			Tahia M. Tagouri, r	32. Begistrar's Signat			kout 1	ca., Le	onard	19XXX	ND 3	0650
	Sta Registr		MAY 9 1 2005	32. Begistrar's Signat		-						
DH	MH 17 Rev 1/2		MICH O A COUJ	Steen D	1							
ULI	17 Dev 1/2	JUI										

ORIGINAL

			1 - For State of M	laryland / Dep		ealth and M	lental Hygie	ene 0 0 5	18224
r	Physic	ian	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	/Medi	cal	Catherine Ardelle ZAHN		1		May 1	4, 2005	8:15 P M
4	Exami	ner	4a. Facility Name (If not institution, give street and number Ravenwood Lutheran Village			Location of Death		4c. County of Deat	
	Funeral			ge (In yrs. last birthday)		If Under 24 Hrs.	8. Date of Birth	Washing 9. Birt	
ь	Director		705-12-5798 1□M 2⊠F	100 Yrs.	Months Days	Hours Min.	(Month, Day, Y Aug. 9,1	904 Mar	hplace (State or Foreign untry) yland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d Inside City Limits
	Manyli 1 sho	0	Maryland Washington		erstown				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	r 28a-	irect	10e. Street and Number	1 1146	10f. Zip Code		10g	. Citizen of What Co	untry?
	th with	Funeral Director	18833 Preston Road			21740		USA	
	r dea	Iner	11. Marital Status 12. Was Deceden Armed Forces	t Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	s afte	y Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ♣ If Yes, Give Year or Dates:	No	1 ☐ Yes 2√∑ No	Specify:	,	Specify:	5, 516.
8	within 72 hours after death with the Maryland ene. than "naturel", or Items 23e or 28e-f show he Medical Examirer must be notified at	Completed by	15. Decedent's Education	16a. Dece	dent's Usual Occupa	tion	16	b. Kind of Business/	hite
215	hin 73	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	(Give	kind of work done of DO NOT use retired,	uring most of work	ing		
7	ed wil ygien tar th	Con	12 0	hom	emaker			her own 1	nome
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. itiam 27 Is markad other than "naturet", or Items 23s or 28s-f show other traumatic event, the Medical Examirer must be notified at	Be	17. Father's Name (First, Middle, Last) Frank S. Bowman				e (First, Middle, Ma E. Stewar		
Z	should nd Me mark imatic	ဥ	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street a			tity or Town, State, 2	(in Code)
	and 2 salth a n 27 Is		Linda Z. Groo - daughter					, Virginia	
ore,	es 1 an of Heal fitam 2 rothar		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo	osition (Name of matory or other place			c. Location - City or	
Ĕ	Pages ment of I ant: If its ury or o		'4 □Donation 5 □ Other (Specify)		1 Cemeter	y 5/18		_	, Maryland
Baltimore,	permit. Pages Department of Important: If is any injury or once.		21. Signature of Euneral Service Licensee	Muy La	45 E. Wil			NERAL HOMI town, Md.	
			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	d the death. Do not ent ine.	ter the mode of dying	, such as cardiac o	or respiratory arrest		Approximate Interval Between
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	no-voscu	dow a	ecident	-		Onset and Death
	Examiner		Due to (or as	a consequence of):		ecident			NE NO PORTO
	No.	ē	Sequentially list conditions, I any, loading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of):	airias	e	12		24ians
	cuted nd ransit	Examiner	that initiated events						
ó,	te be executed ysician and ie burial-transit	Ex	resulting in death) Last Due to (or as	a consequence of):					
8760,	icate b physic s the b	dlcal	d						
9 X	eath certific attending p for use as	/Med	IF FEMALE: 23c. If yes, outcome	of pregnancy				004 B-4(4-1)	
Вох	death atter	clar	in the past 12 months?	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli-	very Day Year
P.O.	at the de by the	Physician/M	9 ☐ Unknown		., ,,				
	es that igned to be det	by P	Part II. Other significant conditions contributing to death	out not resulting in the u	nderlying cause give	n in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ord	w requir been si should						1 Tes	2 □ No 3 □ Pro	obabiy 4 🔯 Unknown
Records,	a sc	Completed					24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
alF			os Warranda de la la la la la la la la la la la la la			<u>-</u>	performed 1 ☐ Yes 2	1? death? No 1 ☐ Yes	21 X No
Vital	Physicien: this certificatal director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpati	ent 2 ER/Outpatien	othe	26. Place of Death		e 6 □Other (Spec	
J Of	g Phy ter thi	n: T	27. Manner of Death 28a. Date of Injury				28d. Describe how i		ny)
sior	Attanding I r death. ector: After by the funer	atio	2 Accident investigation	ly 70a7 Injury		es 2 □No			
Division		Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of In building, e	jury - At home, farm, str tc. (Specify)	eet, factory, office		28f. Location (Stree City or Town, S	t and Number or Rui tate)	ral Route Number,
	Hospitel		29a. Certifier 12 Certifying Physician: To the best	of my knowledge, death	2 Constant of the time	to data and store			1
	To tha Hospitel or within 24 hours afte To tha Funarel Dir completely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	it examination and/or inv	vestigation, in my opi	nion, death occurre	and due to the caus ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the Hospitel within 24 hours a To the Funarel I completely filled	Me	29b. Signature and title of certifier		29c. License		29d.	Date signed (Month	Day, Year)
			Mayar Isuaf		D283	65	S	- 16.05	
H	-2		30. Name and address of person who completed dause of MAWZAR. J.SHAFI	death (Item 23a) (Type, 368 mills	Street +	tagerstou			
:	Sta Registr		31. Date filed (Month, Day, Year) 32. Regist	368 mills rar's Signature	entre				

Leaders Number Control State S				For State Registrar	State of M	laryland / Dep		Health and N	Mental Hygi	ene 0 0 5	18225
May 6, 2005 12:05 P May 6, Compared the mode of compared the mode of				1. Decedent's Name (First, Middle	Last)				2. Date of Death		3. Time of Death
Security Processor Securit				Yi Cheng Zhang							12:05 P M
Social Services Social Ser				4a. Facility Name (If not institution,	give street and number)	4b. City, Town, o	or Location of Death			
216-13-5458 10 # OFF 10 Corp. Four or Location 10				12912 Creamery	Hill Drive		Germant	own		Montgome	ry
The part of the pa		Funeral							8. Date of Birth	(ear) 9. Birth	nplace (State or Foreign
To See to the control of the control		Director			TLM ZXF	74 Yrs.			06/18/1	930 Chi	na
Elementary/Secordary (0-12) Codings (1-4or 5+)		and				10c. City. Town or Le	ocation			1	10d Inside City Limits
Elementary/Secordary (0-12) Codings (1-4or 5+)		danyi f sho	৳		n 0 1811						
Elementary/Secordary (0-12) Codings (1-4or 5+)		the t	rect		пету	Takoma Fa			100	Citizen of What Co	
Elementary/Secordary (0-12) Codings (1-4or 5+)		3a or		7620 Maple Ave	nue. Ant. #	623					
Elementary/Secondary (0-12) College (1-4or 5+)		death ms 2	Jera		12. Was Decedent			fispanic Origin? (Sp	pecify Yes or No-		ican Indian,
Elementary/Secordary (0-12) Codings (1-4or 5+)	9	after or Ita	Ē	1 Never Married 2 X Marrie	id 1 ⊟Yes 2 🔀	No			o Rican, etc.)	Black, White	, etc.
Elementary/Secordary (0-12) Codings (1-4or 5+)	03	ral', c	by	3 Widowed 4 Divorced	Year or Dates:		1∐ Yes 2 <u>K</u> INo	Specify:		Specify: As	ian
Burnal 2 MCremation 3 Renovation State Metropolitan Crem. 05/13/2005 Alexandria, Virginia 22 Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a Part Fore the disease, or complications that caught the Part 25a Part Fore the disease, or complications that caught the Part 25a Part Fore the disease, or complications that caught the Part 25a Part Fore the disease, or complications that caught the Part 25a Part Fore the disease, or complications that caught the Part 25a Part Fore the disease, or complications that caught the Part 25a Part Fore the disease, or complications that caught the Part 25a Part Fore the disease, or complications that caught the Part 25a Part Fore the disease, or complications that caught the Part 25a Part Fore the disease, or complications that caught the Part 25a Part Fore the disease, or complications that caught the Part 25a Part Fore the disease, or complications that caught the Part 25a Part Fore the disease, or complications that caught the Part 25a Part Fore the disease, or complications that caught the Part 25a Part Fore the disease, or complications that caught the Part 25a Part Fore the disease, or complications that caught the Part 25a Part Fore the disease, or complications that caught the Part 25a Part Fore the disease, or complications that caught the Part 25a Part Fore the disease, or complications that caught the Part 25a Part Fore the disease, or complications that caught the Part 25a Part Fore the disease, or complications that caught the Part 25a Part Fore the Part 25a Part Fore the Part Fore the disease, or complications that caught the Part 25a Part Fore the Part Fore the disease, or complications the Part Fore the disease, or complications the Part Fore the disease, or complications the Part Fore the disease, or complications the Part Fore the disease, or complications the Part Fore the disease, or complications the Part Fore the disease, or complications the Part Fore the d	5-0	72 h natu	etec			16a. Dece	dent's Usual Occup	pation during most of work	kina 16	6b. Kind of Business/I	ndustry
Burnal 2 Microalition School Scho	2	Althin ne.	ldu		College (1-4or	5+) life.	DO NOT use retire	d)			
Burnal 2 Microalition School Scho	2	llad v lygie her t		17 Enthoda Namo (Eint Middle I	· · · · · · · · · · · · · · · · · · ·	Gyne	cologist				
Burnal 2 Microalition School Scho	anc	t be find the 00		ast)							
Burnal 2 Microalition School Scho	Ž	d Mei nark	၉		o (Time Oriet)	405-14-7					
Burnal 2 Microalition School Scho	Ma	d2sl han 7 is r traun			p (Type, Print)						
Burnal 2 Microalition School Scho	e,	1 an Healt em 2 ther				20b. Place of Dispo	Maple Ave	enue, Apt			
23. Part: Eriter the disease or compilications that caughd the pleash. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate disease or condition A Years	ō	agas nt of :: If it		1 🗆 Burial 2 🔀 Cremation		'		1			
23. Part: Eriter the disease or compilications that caughd the pleash. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate disease or condition A Years	틆	ritme ritant njung			-						Virginia
23. Part: Eriter the disease or compilications that caughd the pleash. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate disease or condition A Years	Ba	perm Dapa Impo any i		21. Signature of Fullera Service L	Carlisae			_	-		0.00
Commonstrate Course (Final disease or condition resulting in death) Course (Final disease or condition resulting in death) Course (Final disease) Condition Course (Final disease) Cou				23a Part 1 Enter the disease or o	amplications that cause						
Column C	Н				nly one cause on each	ine Joans Do not em	er the mode of dyn	ig, such as cardiac	or respiratory arres	4.	Interval Between
Sequentially ist conditions and year of the past 12 months? FEMALE 23c. if yes, outcome of pregnancy 1 1 1 1 1 1 1 1 1				disease or condition							
The property of the property o					Due to (or as	a consequence of):					
The property of the property o		es.	-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):					
Section Color Co		ansit	듄	Cause Disease or injury							
Section Color Co	Ć,	exect n and ial-tra	Exa			a consequence of):					
FEMALE. 23b. Was decedent pregnant in the past 12 months? 1 1 2 5 Felal death 2 5 Month Day Year 2 2 Month Day Year 2 Month Day Month Day Year 2 Month Day)9/	e ba /sicia e bur	cal		d						
Part II. Other significant contributes contributing to death out not resulting in the underlying cause given in Part I. 1	9	.9 4 (0									
Part II. Other significant contributing to death out not resulting in the underlying cause given in Part I. 1	ŏ	andin usa	N/W							23d. Date of deliv	erv
Part II. Other significant contributing to death out not resulting in the underlying cause given in Part I. 1		deat	Cla		4☐Pregnant a				<u> </u>	Month	Day Year
Part II. Other significant contributing to death out not resulting in the underlying cause given in Part I. 1	Ö	by th	hys		9LJ Unknown						
1 Yes 2 No 3 Probably 4 Monknown		as the		Part II. Other significant condition	s contributing to death t	out not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tobac	co use contribute to t	he cause of death?
Second S	g	en si							1 🗆 Yes	2 ☐ No 3 ☐ Prol	pably 4 X Unknown
Second S	ပ္ပ	law re as be 2 sho	plet								
26. Place of Death (Check only one) 27. Manner of Death 1 Natural 5 Pending 28. Date of Injury 28b. Time of Injury 3 Suicide 4 Homicide 28c. Injury at Work? M 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how i	Ě	The hard	E O						performe	d? death?	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Ambinder, MD, 1650 Orleans Street, Baltimore, Maryland 21231	ita	ian: ntifica ctor, I	a					26. Place of Deat		10 103	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Ambinder, MD, 1650 Orleans Street, Baltimore, Maryland 21231	>	nysic nis ce direc	.0		Hospital: 1 Inpatie	ent 2 ER/Outpatien	t 3 DOA Oth			e 6 X Other (Specif	Daughter's
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Ambinder, MD, 1650 Orleans Street, Baltimore, Maryland 21231	0	ng Pl			28a. Date of Inju	ry Year) 28b. Time of	28c. Injun	y at k?	28d. Describe how	injury occurred	Residence
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Ambinder, MD, 1650 Orleans Street, Baltimore, Maryland 21231	Sio	endii eath. or: A che lu	atle	2 Accident investiga	tion						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Ambinder, MD, 1650 Orleans Street, Baltimore, Maryland 21231	Ξ̈́	r Att ter de irect irect	Ħ	datamin	ed 286. Place of In	ury - At home, farm, stri c. (Specify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Rura State)	al Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Ambinder, MD, 1650 Orleans Street, Baltimore, Maryland 21231		ital c ral D lad ir	Ce								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Ambinder, MD, 1650 Orleans Street, Baltimore, Maryland 21231		Hosp 4 hou Fune ely fil	ical	(Check only 2 Medical E.	caminer: On the basis o	f examination and/or inv	occurred at the time	ne, date and place, pinion, death occurr	and due to the caus	e(s) and manner as s	tated.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Ambinder, MD, 1650 Orleans Street, Baltimore, Maryland 21231		the the I	Med	5110)	and manner st	ated.					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Ambinder, MD, 1650 Orleans Street, Baltimore, Maryland 21231		So Twit		250, Signature and title of centimer	(4	0	29c. License	2: 2 5		Date signed (Month,	Day, Year)
Richard Ambinder, MD, 1650 Orleans Street, Baltimore, Maryland 21231		/		iny		~	DO	033	2813	211010,	5
State Registrar Richard Ambinder, MD, 1650 Orleans Street, Baltimore, Maryland 21231 31. Date filed (Month, Day, Year) MAY 1 3 2005 Registrar		5		· ·						b	
Registrar MAY 1 3 2005				Richard Ambinder	MD, 1650	Orleans St	reet, Bal	Ltimore, N	Maryland	21231	
			ie ar	MAY 1 3	2005	er Sh	sell				

			For State Registrar	State of Mary	land / Depa		lealth and		giene	5	18226
			Hegistrar 1. Decedent's Name (First, Middle, Last)			inoate or i	Dealit	2. Date of Dea	Reg. No.		3. Time of Death
	Physici		Melva S. Arnold					Month May		Year 005	11:40 p M
)	/Medic Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of De	-	4c. County o		11.40 р
	ē.		St. Joseph's Nursi	ing Home		Cato	nsville		Bal	timo	re
	Funeral Director		212-07-0351		n yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 H	in. 8. Date of Birt (Month, Day 0ct. 25	/, Year)		ace (State or Foreign try) yland
	land W		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ocation				10	Od. Inside City Limits
	within 72 hours atter death with the Maryland ene. than "netural", or Itama 23a or 28a-f ahow Ita Mudical Extratinat Le mulliad at	tor	MD Balti	more		Balti	more				1 ☐ Yes 2X☐ No
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wi	nat Coun	try?
	th wit		5934 Central Avenu	ıe			21207		United	Stat	es
	ama	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of H	ispanic Origin? In, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race Black	- Amenca White, e	
36	or It		1 Never Married 2 Married 3 Midowed 4 Divorced	1 ∐ Yes 2 ZŽNo lf Yes, Give		1 ☐ Yes 2 🕅 No			Specify:	W	hite
8	tural	ed b	15. Decedent's Educ	Year or Dates:	16a, Dece	dent's Usual Occup	ation		16b. Kind of Bus	iness/Ind	lustry
75	n "na	plet	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of (working	100.11		
21215-0036	filed with Hygiene other tha ent, the	Completed by	12	College (1-401 34)		Bookkeep	er		Merc	anti	le Bank
ng	al Hy al Hy d oth	Be (17. Father's Name (First, Middle, Last)					Name (First, Middle,	Maiden Sumame)	
yla	2 should be I and Mental I is marked o aumatic eve	ဥ	Albert Schrade					Fidler			
Maryland	C1 00 00		19a. Informant's Name/Relationship (Ty)					Rural Route Numbe			Code)
	1 and Health em 27 ther t		Nancy Gunkel Daug 20a. Method of Disposition	hter				Baltimor	e, MD 21 20c. Location - C		wn. State
Baltimore,	Pages nent of thant: If its ant: If its ury or o		1X Burial 2 ☐ Cremation 3 ☐ R	empyarmom state		osition (Name of matory or other place		/ 0005		•	
	artme ortani injury		'4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral / spice Licence	A		ark Cemet		mbrose Fu	Baltimor peral Ho		
Ba	Depa Impo any i		Some to	truple				ng Rd., A		-	
			23a. Part1. Enter the disease of compli- shock, or heart failure. List only on	cations that caused the							Approximate Interval Between
	ੂੰ Pnysician		Immediate Cause (Final		cac info						Onset and Death
	/Medical		disease or condition resulting in death)	Dife to (or as a co		ICHON					
e	Examiner		Sequentially list conditions).							
	D ==	lner	if any, leading to immediate	Due to (or as a co	onsequence of):					- 6	
	and and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	negationes of):				_		
760,	be executed sician and burial-transit	ical E		200 10 (01 23 2 00	risaquarioe or).						
687	ficate physics the		0	J							
Box (leath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of p					23d. Date	of delive	ry
ŏ.	death e atte	Cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2□ 4□Pregnant at time		□Ectopic pregnancy □ Other (specify)			Mont	h .	Day Year
P.O.	by the	hys	9 Unknown	9□ Unknown							
	The law requires that the death certificate be executed tte has been signed by the attending physician and age 2 should be detached for use as the burial-transit	by P	Part II. Other significant conditions con		,		en in Part I.		bacco use contrib		
Records,	w require been sign should t	Completed	Hypertensive a	Heriesclei	TOTIL CE	promary	artery	_ 1□Y	es 2 No 3	□ Proba	ably 4 Unknown
ec	has by	nple	disease					24a. Was autop	sy / pri	or to con	sy findings available appletion of cause of
	: The							perfor		ath?] Yes	2 No
<u>≅</u>	Physician: rthis certifica ral director, I	Be	25. Was case referred to medical examiner?	fospital:		Oth	00	Death (Check only of			
o	Physician: The la r this certificate has iral director, page 2	. To	1 ☐ Yes 2 ☑ No H	1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatier	II JUDOA	4 Nursing	g Home 5 Resid	ence 6 Other ow injury occurred)
O	ding Afte fune	tlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye	oar) Injury	Wor	k? Yes 2 □ No		, , ,		
Division of Vital	l or Attending after death. Director: Atter In by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, str	reet, factory, office		28f. Location (S	treet and Number	or Rural	Route Number,
	s afte	Cert	4 Homicide	building, etc. (8	ppecity)			City or Tow	п, Зіатө)		
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in by		(Check only 2 Medical Examir	sician: To the best of m	y knowledge, deat	h occurred at the tin	ne, date and pla	ace, and due to the c	ause(s) and mani	ner as sta	ated. the cause(s)
	hin 2. the F	Medical	one)	and manner stated		29c. Licens					
	To To cor	-	29b. Signature and title of certifier	- 00	1.10				29d. Date signed		
	./		o Norman and	accaga,	(110= 22=1 7	Dol Dol	786		June		
	5		30. Name and address of person who co	10 - 0	716 N	Widon C	holee	Lane f	BacTo,	na	3/228
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	5 4	41		1		V. 200
	Registr		JUN	0 1 2005	Carrer A	K Sport	20				

State

Registrar

32. Registrar's Signature

1 2005

		State of Maryland / Department of Health and	-	•	
		1- Stete Registrar Certificate of Death		Reg. No.	18228
Physic	an	1. Decedent's Name (First, Middle, Last)	2. Date of D	eath Day Year	3. Time of Death
/Medi	cal,	William A. Anderson	MAY	3/ 2005	11:45 A.M.
Examir	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat	th	4c. County of De	
Funeral		North Arundel Hospital Glen Burnie 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Bi	Anne A	rundel inthplace (State or Foreign Country)
Director		028-09-0311 12M 2DF 95 Yrs. Months Days Hours Min.			ssachusetts
land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
. Marylan a-f show	tor	Maryland Anne Arundel Millersville			1 ☐ Yes 2 ⊡1¶o
with the Marylar a or 28a-f show	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	Country?
sath w	rai	575 Brightview Drive 21108		U.S.	
fler de	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 □ Never Married 2 □ Married 1 □ Pres 2 □ No	to Rican, etc.)	o- 14. Race - Arr Black, Wh	
DERSON 1215-0036 within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-1 show the Maryland the Maryland the Maryland at the Maryland the Maryland at the Maryland the M	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: W. W. T.T		Specify:	White
15-0 15-0	etec	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of wo life. DO NOT use retired)	rking	16b. Kind of Busines	
O 2121E d 2121E Hygiene.	dmo	Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Supervisor		T D	-1 C O
	Be Completed by	Supervisor	me (First, Middle	Lever Bro e, Maiden Sumame)	thers Soap Co
arylan, should be not Mental or marked or umatic eve	To E	George Anderson Anna		An	derson
Mar Mar 12 shc h and 7 is m		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Re		The Contract of the Contract o	er un oppositioner
ire, Maryland ? ire, Maryland ? s 1 and 2 should be filed files and Mental Hy item 27 is marked othe		Robert W. Anderson (Son) 575 Brightview Drive 20a. Method of Disposition (Name of commetter), crematory or other place)	Millers Date	ville, Mary	
Pages nent of ant: If its		1 Double 2 Comment of State	1/05	Baltimore	
inji inji		21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak I		Dattimore	, mary rand
Be mp be and and and and and and and and and and		John F. Collins 3204 Mountain Road	d Pasade	Home, P.A. Pna. Maryla	nd 21122
36		23a. Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac short, or heart failure. List only one cause on each line.	c or respiratory a	arrest,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			Onset and Doath
Examiner		Due to (or as a consequence of):			
V 7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
A ecuted	Examiner	triat initiated events c.			
760, te be executed sysician and se burial-transit	cai E	Due to (or as a consequence of):			
687(inficate by g physical as the k		d.			
Box 68 leath certificat attending phy	an/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of de	,
Vision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed redath. •ctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Med	in the past 12 nonths? 1		Month	Day Year
IS, P.O. es that the de igned by the 2	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use contribute t	to the cause of death?
rds, quires on signo	d be		1 🗆	Yes 2 No 3 P	robably 4 Unknown
Record law requir has been si	Completed		24a. Was	s an 24b. Were a	utopsy findings available completion of cause of
The late ha	Com		perfe	ormed? death?	1
Vital F ician: Th certificate	Be	examiner?	ath (Check only		
g Phys er this	To	1 Tes 2 No 1 Annatient 2 ER/Outpatient 3 DOA 4 Nursing F		idence 6 Other (Spe	ecify)
ision of Vita	atior	27. Manner of Death Natural 5 Pending Accident Investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 38c. Injury at Work? 1 Yes 2 No			
Division of Vital Records, to Attending Physicien: The law requires taller cleath. Director: Atter this certificate has been signed in by the tuneral director, page 2 should be control to the tuneral director.	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Number or Riwn, State)	lural Route Number,
Dital cours af		CO. Continue Distriction To the Continue of th			
Divi To the Hospital or At within 24 hours after To the Funeral Direct completely filled in by	Medicai	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place (Check only one) Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (Check only one)	e, and due to the irred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
Division To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mon	th, Day, Year)
		1 D43977		May 31	2005
6X1		20. Name and address of person who completed cause of death (Item 23a) (Type, Print)	\$ 1a	00 310	1)
Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	nc. W	20	0/
Registr		JUN 0 1 2005 Degree & Special			

			1 - For State Registrar	State of	Marylan	_	artment rtificate			and M	lental Hy	giene Reg. No. 2	105	100	220
	Physici	ian	Decedent's Name (First, Middle								2. Date of Dea	ath Day	Year	3. Time of	
	/Medi	cal		llendort	- f 1		4 0: -	-			05		2005	12:08	3 PM
	Examir	ner	4a. Facility Name (If not institution Mercy Melli	cal Cente			-		Location of				ty of Death		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under		8. Date of Birt	h	9. Birth	place (State of	r Foreian
	Director		220-202404	1□ M 2□ F	76	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da April I	2, 1929	Mary	place (State of ntry) (Land	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	v. Town or Lo	cation							10d. Inside Cit	h. Limita
	Maryl. f sho	ō		n/a		Baltin								1XXVes	,
	r 28e	rec	10e. Street and Number				10f. Zip	Code	_			10g. Citizen of	What Cou	ntry?	
	th with	a D	635 E. Fort Av	e.			2	21230)			United	l Stat	ces	
	r dea	Funeral Director	11. Marital Status	12. Was Dece Armed For	dent Ever in U.	S. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)	14. Ra	ice - Ameri ack, White,		
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Mar 3 ☐ XWidowed 4 ☐ Divorced	If Yes Give	2 No		1 ☐ Yes 2		Specify:		,,	Speci		nite	
9	72 hours after death with the Maryland neturel', or Items 23a or 28e-f show liked Examiner must be motified at	ed	15. Deceden	it's Education		16a. Dece	dent's Usua	I Occupa	ition			16b. Kind of E			
215	hin 7.	Completed	(Specify only highe Elementary/Secondary (0-12)	st grade completed) College (1-	-4or 5+)	(Give life.	kind of wor DO NOT us	k done d e retired)	uring most	t of worki	n <i>g</i>				
21	ygien ygien yer th	Con	6 years			Homen	naker					C	wn Ho	ome	
Maryland 21215-0036	2 should be filed within 72 hours after dea and Mental Hygiene. is marked other then "neturel", or Items eumatic event, It a Medical Examinet or	Be	17. Father's Name (First, Middle, Herbert Halber								(First, Middle, T. Corn		me)		
Ž	hould Id Me mark matic	2	19a. Informant's Name/Relations			19h Mailir	na Address	(Street a			I Route Numbe		Ctata Zir	Codel	
	nd 2 s lith ar 27 is r treu		Earl Gallion (B								more, M		-	Code	
Je,	of Heal		20a. Method of Disposition		1 -	lace of Dispo emetery, crer	sition (Nam	e of	a)	0	ate	20c. Location	- City or To	own, State	
Ē	Page nent c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (S	3 ∐Removal from S `pecify)	state _	view (•		5-31	-2005	Baltimo	re, N	Marylan	.d
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then *neture1', or Items 23a or 28e-f show emportent: or other treumatic event, If a Madical Examiner must be notified at ODGs.		21. Signature of Funeral Service	J. Wayne	Osterli	$ \begin{array}{c c} & \stackrel{22}{\text{Mo}} \\ & 13 \end{array} $	Cully BO E.	Address Port	s of Facility Lynia Ave	k Fu	neral H Itimore	ome P.A	21230)	
			23a. Part Enter the disease, or shock, or neart failure. List	complications that ca	used the death	. Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Betw	reen
	Physician	9	Immediate Cause (Final disease or condition resulting in death)	a. Muss	ive left or as a consequ	t hem	osoleri	C 5	rok	e				Onset and D	
	/Medical Examiner		resulting in dealth)	Due to (d	or as a consequ	vence of):				•					1
į,	<u> </u>	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury	b. — Due to (d	or as a consequ	vence of):									
$\sqrt{}$	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C											
Ö,	ate be executed hysician and the burial-transit	Exa	resulting in death) Last		or as a consequ	uence of):									
8760,	cate be executed physician and the burial-transit	dlcal		d									_		
9 x	ding p	/Me	IF FEMALE:	23c. If yes, outo	ome of pregna	nev						T			
Вох	requires that the death certifics wen signed by the attending pt hould be detached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live bi	rth 2 ☐ Fetal	death 3	Ectopic pre						ate of delive onth		ear
o.	that the de ed by the detached	hysi	9 ☐ Unknown	9□ Unkno											
S,	signed by det	by P	Part II. Other significant condition	ons contributing to de	ath but not resu	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did to	bacco use con	tribute to th	ne cause of de	ath?
ord	w require been si should b	ted									1 🗆 Y	es 2 🗆 No	3 ☐ Prot	ably 4 🗹	nknown
Records,	2 S X	Completed									24a. Was a	SV	Were auto	psy findings a mpletion of ca	vailable use of
_	Th ate pag										perfor		death?	2 No	
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospitals	<i></i>						(Check only or				
of		: To	1 Yes 2 No 27. Manne of Death	28a, Date o	f Iniury	ER/Outpatien 28b. Time of		le. Injury	' 4 ⊟ Nui at		ne 5 🗆 Resid			y)	
ion	nding tth. :: Afte e func	atlor	1 Natural 5 Pendin 2 Accident investig	9	, Day Year)	Injury	М	lc. Injury Work' 1 □ Y	? es 2 □ N			,,			
Division	I or Attending Phater death. Director: After th In by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could of determined	ined 289. Place	of Injury - At ho g, etc. (Specify	me, farm, stre	eet, factory,	office		2	8f. Location (S City or Town	treet and Numb	ber or Rura	l Route Numb	e <i>r</i> ,
ā	itelo Irs aft rel Di led in	Cer								- 4					
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical	29a. Certifier 1 Certifyin (Check only 2 Medicel one)	g Physicien: To the Exeminer: On the ba	sis of examinat	wledge, death ion and/or inv	estigation,	in my opi	inion, deat	d place, a	nd due to the c ed at the time, d	ause(s) and ma ate and place,	anner as st and due to	ated. the cause(s)	
	To To	2	29b. Signature and title of certifie	Day 1 h	10			License		_		9d. Date signe		Day, Year)	
	a		, 9 ,	Jan 1			44	417	2234	213	C E -	5/27/0	22		
	6		30. Name and address of person #19167 May Cl	respel Red			2109	3 .	Dr.	Hugh	1 Tadeh	MD			
R.	Sta Registr		31. Date filed (Month, Day, Year) JUN 0	16	gistrar's Signat	sure	all!								

			For State Registrar	State of Maryla	_	artment of H <i>Tificate of L</i>			ene I. No. O	
	Physici	an	1. Decedent's Name (First, Middle, La	·				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		Anna Dorothy Bay					May 3	0, 2005	11:30 AM
	Examir	er	4a. Facility Name (If not institution, giv 4 Torhat Court			4b. City, Town, or ESS	Location of Death		4c. County of Death Baltimon	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs	s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birti	hplace (State or Foreign
	Director		199 07 6326	□ M 20XF 84	Yrs.	Months Days	Hours Min.	July 15, 1	920 Penr	nsylvania
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Limits
	Many F-f sh	tor	Maryland Baltimo:	re	Esse	ex				1 ☐ Yes 2 1 No
	h with the	al Director	10e. Street and Number 4 Torhat Court "A	pt E"		10f. Zip Code 2122	1	10g	g. Citizen of What Co USA	untry?
980	4 within 72 hours efter death with the Maryland jiene. r than "naturel", or Items 23a or 28a-f show Itte Mudical Exan il at must be motified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2X No	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Whi	e, etc.
Maryland 21215-0036	within 72 ho iene. r than "natur the Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(Give	DO NOT use retired	furing most of worki	ing	St. Kind of Business/	ounty Gov.
land 2	be filed trail Hyg od othe event,	ě	17. Father's Name (First, Middle, Last Walter Benerovich)				e (First, Middle, Ma	iden Sumame)	
	s 1 and 2 should b f Health and Meni item 27 is marked other treumatic		19a. Informant's Name/Relationship (Mary Ann Newhouse			-			City or Town, State, 2 Land 2104	
Baltimore,	00		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State		sition (Name of natory or other place Cemetery	6/2/2		c. Location - City or altimore,	
Balt	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Lice	wrkowske	Bı	Name and Address Cuzdzinsk 407 Old E	i Funeral	Home P.Z Venue Esse	A. ex, Md. 21	221
	Pnysician /Medical		23a. Paht. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the decone cause on each line. a				or respiratory arrest	t,	Approximate Interval Between Onset and Death
В	Examiner		Sequentially list conditions	h Pws	um o	1 ASC	1			
	be sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse						
68760,	ificate be executed g physician and as the burial-transit	cal Exam	that initiated events resulting in death) Last	C. Due to (or as a conse	equence of):					
	= D ed	/Medical	IF FEMALE:	23c. If yes, outcome of pregi	nancy				23d. Date of deli	ven/
P.O. Box	the death cert by the attending ached for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)			Month	Day Year
Ś	w requires that the de been signed by the s should be detached	by	Part II. Other significant conditions of	ontributing to death but not re	esulting in the ur	nderlying cause give	en in Part I.		cco use contribute to 2 ☐ No 3 ☐ Pro	the cause of death? obably 4≹JUnknown
of Vital Record	The larate has	Completed						24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe		(Check only one)		
	ding Phys n. After this funeral di	ition; To	1 Yes 2X No 27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	4 Nursing no	me 5 🔀 Residenc 28d. Describe how	ce 6 Other (Specinium) occurred	erfy)
Division	- 0	Certification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	To the Hospitel of within 24 hours at To the Funerel D completely filled in	edical	(Check only 2 Medical Examone)	nysician: To the best of my kr niner: On the basis of ekamir and manner stated.	nowledge, death vision and/or inv	vestigation, in my op	pinion, death occurr	ed at the time, date	and place, and due	to the cause(s)
)	To To con	×	29b. Signature and after of certifier	2 AM	~	29c. License	77236		. Date signed (Month	_
/	71		30. Name and address of person who RUDNEY A. JUL	completed cause of death (Ite 32. Registrant Sign 1 2005	em 23a) (Type, I	Print) 59 01	R. SuiTe	209 Ral	70. MD	21237
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar Sign	nature &	Sparke		, 5,0	,	

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 26^{Day}2005^{Year} Month May **Physician** Bogier Albertha 3:00a. M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3835 Cherrybrook Road Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 S.C. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Months Days Hours Year Min 1 M 2X F 217-24-7325 95 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is markad other than "neturel", or items 23s or 28e-f show other traumetic event, the Medical Exeminar must be notified at Randallstown Baltimore 1 Yes 2 No MD Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3835 Cherrybrook Road USA 21133 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Items 23s any injury or other treumetic event, the Medical Examiner must any injury or other treumetic event, the Medical Examiner must gence. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐No þ 3X Widowed 4 □ Divorced Specify. Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Home Homemaker 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) UNK Alice Boyd Johnny 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
21133 19a. Informant's Name/Relationship (Type, Print) 3835 Cherrybrook Rd. Randallstown, MD Beverly Warner-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/31/2005 Carroll Co. MD Lakeview Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MARCH FUNERAL HOME-EAST 22. Name and Address of Facility la S 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Won Baltimore, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** 20 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine signed by the attending physician and ibe detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 □ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 5000 3 Probably cate has been signage 2 should b 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has NRONIE 2 No 2 □ No 1 Tyes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Ne Dence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attanding I within 24 hours after death. To the Funaral Director: After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 T Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔁 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kezulla 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar Blown & Speck

ORIGINAL

ystal M. D	. Bu	ıst 1	State of Maryland / D	ера		ealth and M	lental Hyg	iene	ole.	10000
Phy	/sicia		1. Decedent's Name (First, Middle, Last) Crystal M. Busta		tinicate of t	Jean	2. Date of Death	2005	Year	3. Time of Death
	ledica amine		4a. Facility Name (If not institution, give street and number) 1010 Gateway		4b. City, Town, or Edgewood	Location of Death	11dy 17,	4c. County		OIZJA. W
Fune Direc			5. Social Security Number 6. Sex 7. Age (In yrs. last birth 213-92-1496 1 M 2 F 26 Usual Residence of Decedent	hday) (rs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 19	Year 978	9. Birth	place (State or Foreign ntry) X a S
Maryland	THE CHI		10a. State 10b. County 10c. City, Town Md. Harford	or Lo	Bel Ai	r			1	1 Yes 2 No
ith with the 23a or 28a		al Dilec	10e. Street and Number 2018 Thomas Run Road		10f. Zip Code	1015		g. Citizen of \J.S.A.	What Cour	ntry?
Baltimore, Maryland 21215-0036 permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-1 show any inline or 200.	- Xaminetin	completed by runeral billector	11. Marital Status 1 □Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □No If Yes, Give Year or Dates:	i	Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 🛣 No	spanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		k, White,	can Indian, etc. ite
Baltimore, Maryland 21215-0036 bernit. Pages 1 end 2 should be filed within 72 hours all Department of Health and Mental Hygiene. Important: If least 21 is marked other than "natural", or within the marked other than "natural", or within th	le wooleel	nipiere	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life.	dent's Usual Occupa kind of work done d DO NDT use retired, maker	ition uring most of work	ing	6b. Kind of Bi		dustry
/land 2	To be of	0	17. Father's Name (First, Middle, Last) Marvin D. Wischnack			18. Mother's Name Karen I	e (First, Middle, N E. Busta	laiden Surnan	10)	
end 2 sho	ler trauma		Karen Busta/mother	18	ng Address (Street a Meadowoo	d Drive,	Edgewood	City or Town,	State, Zip 2104	O Code)
timore trent of H trant: If ite	land or our		'4 Donation 5 Other (Specify) Bayvie	₽W	sition (Name of natory or other place Crematory	6/1/2	2005	Baltin	ore,	Md.
Dermii Depar	SUC SUCCE		21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do no		2. Name and Addres Schimunek 610 W. Ma er the mode of dying	cPhail Ro	ad, Bel	Air, M		nc. 1014 Approximate
Pnysici /Media	cal		shock, or heart failure. List only one cau an each line. Immediate Cause (Final disease or condition resulting in death) a. Use to (or as a consequence of the cons	N	ound 1	to Hea	-C	J.,		Interval Between Onset and Death
3760, ate be executed XIII vysicien and XIIII in the burial-transit		במו דע	Sequentially list conditions, if any, leading to this ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Disa to (ar as a consequence or consequ	Ŋ:						
Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the ettending physicien and hand 2 should he dearched for use as the burial-transit	elaction to use as it	I yalcıdı izined	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No Toknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown		Ectopic pregnancy Other (specify)			23d. Dat Mo	e of delive	ery Day Year
Records, P. he law requires that e has been signed b	and be determined by D		Part II. Other significant conditions contributing to death but not resulting in	the u	nderlying cause give	n in Part I.	23e. Did toba			ne cause of death? ably 4 ∐Unknown
I Rec	v (24a. Was an autopsy perform 1 Yes 2	ed?	rior to cor teath?	psy findings available inpletion of cause of
- × · · · · ·	J L	2	25. Was case referred to medical examiner? 1 2 Yes 2 No Hospital: 1 Inpatient 2 EP/Out,	patien	t 3□ DOA Othe	26. Place of Death	n <i>(Check only one</i> me 5 ☐ Resider		ar (Specifi	(scene)
Division of To the Hospital or Attending Phys within 24 hours efter death. To the Funeral Director: After this completely filled in by the funeral this	ed in by the tuneral		2 Accident investigation 3 Suicide 6 Could not be	5	Work M 1 □ Y	? 'es 2/No	28d. Describe how Subjection (Street	v injury occurr	Lot	
Division To the Hospital or Attending within 24 hours effer death. To the Funeral Director: After composate (in by the funeral principles)	THE COLUMN		29a. Certifier 1 Certifying Physician: To the best of my knowledge,	7			City or Town,	State)	1 2	1040
To the Ho within 24 h To the Fu	Modical and	MCCIC	(Check only one) 25 Medical Examiner: On the basis of examination and and manner stated. 29b. Signature and tiple of Certifier	Vor inv	vestigation, in my op 29c. License	inion, death occurr	ed at the time, da	te and place, a	ind due to	the cause(s) Day, Year)
)		-	30. Name and address of person who completed cause of death (Item 23a) (1	- - -	OCM	Œ		May 19	, 200	
	State		31. Date filed (Manth Day, Year) 2005 22. Registrar's Signature	, 1 ha.		nn Stree	t Ba lti m	ore Mai	ylan	d_21201
Reg	gistraı		JUN 0 1 2005 Here & A	200	Ro					

State of Maryland / Department of Health and Mental Hygiene 18233 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2005 **Physician** May 24, Beatrice V. Blanchard 7:45 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1501 Hanson Road Edgewood

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Harford 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 177-03-6358 1 □ M 2 □xE 98 Director July 21. 1906 PA Usual Besidence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Harford Director Edgewood 1 ☐ Yes 2X No Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1501 Hanson Road 21040 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 Is marked othar then "natural", or Ite 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white þ 3. Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NDT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years bookkeeper accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Roy Wise Flossie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendy Sawyer/daughter P.O. Box 1056, Edgewood, Md. 21040 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 permit. Page Department of Important: If any injury or once. * 4 □ Donation 5 □ Other (Specify) Arlington Nat'l Cem. 6/13/2005 Arlington, Va. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. Ste serves 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Congestive heart failure months /Medical Due to (or as a consequence of): Examiner Hypertension years Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last be executed the burial-transit Atrial fibrillation months and Due to (or as a consequence of) Box 68760 the attending physician Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 🖾 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 20 No Division of Vital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 TResidence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA the funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After 1 XNatural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident s after death 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address operson who completed cause of death (Item 23a) (Type, Print) May 25, 2005 Craig Shaughnessy, M.D., 104 Plumtree Road, Ste. 115, Bel Air, Md. 21014 JUN 0 1 2005 32. Registrar's Signature 31. Date filed (Month) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

	_	For Stata	State of Maryland / Department of Health and I	Mental Hygie	ene	10001
		Registrar 1. Decedent's Name (First, Middle, Las	Certificate of Death	Reg 2. Date of Death	. No. UU	18234
Physician /Medical	1	Pearl Ne	the Bimline	Month MAY	Day 2005	3. Time of Death 5: 10 A
Examiner Funeral Director		4a. Facility Name (If not institution, give	Center Towson		0.0:-	MORE hplace (State or Foreig
yland		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	July 1	31-1-10	10d. Inside City Limit
urs after death with the Maryland al, or itams 23a or 28a-f show yar it errust be rediffed at by Funeral Director		10e. Street and Number	tord therdeen	10g	. Citizen of What Co	1 ☐ Yes 2 ☑ No
ms 23a c		215 Schmed 11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent ol Hispanic Origin? (S	pecify Yes or No-	USF 14. Race - Ame	nican Indian,
ours after ral', or ita		1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: If Yes, Specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☑ No Specify:	to Rican, etc.)	Specify:	hite
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or itams 23a or 28a-i show any injury or other traumatic avent, the Medical Evertic entrust be notified at once. To Be Completed by Funeral Director		15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)	rking 161	b. Kind of Business/	Industry Short Str
ould be filed v Mental Hygie arked other i atic avent, tt		17. Father's Name (First, Middle, Last)	ODE 18. Mother's Nan	me (First, Middle, Mai	iden Sumame)	000
and 2 should all the and Men n 27 is marke for traumatic.	-	19a. Informant's Name/Relationship (7	ype, Print) Grand 19b. Mailing Address (Street and Number or Ru 10c. (Street and Number of	iral Route Number, C	ity or Town, State, Z	Tip Code)
Pages 1 a nent of He ant: if itam ury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify		_	Location - City or	Town, State Marylano
permit. Departr Importa any inji		21. Signature of Funeral Service Licer		KRD, Tin	10W. UM P	10 21093
Physician		Immediate Cause (Final disease or condition	lications that caused the death. Do not enter the mode of dying, such as cardiac his cause on each tine.	or respiratory arrest,		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death) Sequentially list conditions,	Due to (or as a consequence of):			VICEA
executed in and ial-transit		ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):			
ficate be executed physician and is the burial-transit edical Examin		esulting in death) Last	Due to (or as a consequence of):			
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transition property of the burial-transition by the physician/Medical Exami		F FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		25d Eate of delin Month	nery Day Year
w requires that been signed b should be deta	Ι.	Part II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to	V
				24a. Was an autopsy performed	prior to condeath?	opsy findings available ompletion of cause of 2 No
Physician: The this certificate al director, pag: To Be Co		1 193 2 10	doenital:	th <i>Check only one)</i> ome 5 Residence	6 A ther (Spec	innospia
Attanding P death. ctor: After t y the funera	1	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred	•
To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St	tate)	
To the Hosp within 24 hou To the Fune completely fil	_	one 2 Medical Exam	sician: To the best of my knowledge, death occurred at the time, date and place, nar: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the cause rred at the time, date	e(s) and manner as and place, and due to	stated. to the cause(s)
To corr		29b. Signature and ditte of certifier	29c. License number D 58303	10.4	Date signed (Month,	1/201
9		Amon Charles	completed cause of death (Item 23a) (Type, Print) COOL N- CHANCE ST Ru	ltimore	MD 212	404
State	1	11. Date liled (Month, Day, Year)	32. Registrar's Signature			

			1 - For State Registrar			nd / Depa	artment of H	ealth and I	Mental Hyg	2000	1000
			Decedent's Name (First, Middle, Last)				tinoate or i	Jean	2. Date of Deat		3. Time of Death
	Physic		Madeline M. Ba	nier					Month May	Day Year	
	/Medi Examir		4a. Facility Name (If not institution, give s		er)		4b. City, Town, or	Location of Death		26 2005 4c. County of Death	7:55A. M
			Casey House				Rockvi1	1e		Montgome	
T	Funeral		Social Security Number 6. Sex		Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		iplace (State or Foreign intry)
ŧ.	Director	١.	138-12-1423	M 21⊠ F		83 Yrs.	Months Days	Hours Min.	Aug 23,	1921 New	York
	and		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation				101
	Manyl f sho	5									10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the 1	Director	Maryland Howard 10e. Street and Number		н	igh1an	10f. Zip Code		10	g. Citizen of What Cou	
	3a or		7049 Mink Hollow	Road				777			muy?
	death ms 2	Jera		2. Was Decede		.S. 13. V	Vas Decedent of Hi Yes, specify Cuba		pecify Yes or No-	U.S.A.	ican Indian
9	after or Ite	Ē	1 Never Married 2 Married	Amed Force					Rican, etc.)	Black, White	
ဗ္ဗ	ours ral',	1 by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Date	s:		☐ Yes 2 1 No	Specify:		Specify: Whi	te
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Exan ar mat ke motified at	Completed by Funeral	15. Decedent's Educ (Specify only highest grade	ation completed)		16a. Deced	ent's Usual Occupa kind of work done of OO NOT use retired	ition Juring most of wor	kina 1	6b. Kind of Business/I	ndustry
12	within no. than	ם	Elementary/Secondary (0-12)	College (1-4c	or 5+)						
	filed v Hygie other t	ပိ	12 17. Father's Name (First, Middle, Last)			Denta.	l Assista		- (F ^o i A	Dental	
Maryland	d be antal	o Be	Leonard Zeisler						ne (First, Middle, M	aiden Sumame)	
2	should ind Men marke	ပ	19a. Informant's Name/Relationship (Type	e. Print)		19b Mailin	n Address (Street a	Teresa		City or Town, State, Zi	- 0-4-1
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event; the Madical Exammer must be notified at any injury or other traumatic.			ughter)			Mink Holl			l, Maryland	
altimore,	s 1 a f Hea item othe		20a. Method of Disposition		20b. P	because the second of the seco	sition (Name of place		_	Oc. Location - City or T	
Ë	Pages nent of I int: If its ury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	moval from Sta	10		sh Cremat		-2005 T	aurel, Mar	vv1 and
alt	permit. Departn Imports any inju		21. Signature of Funeral Service Licen e	1	11		Name and Addres			darer, nar	yrand
<u> </u>	8258		Max	all		5	לכם Twin	Knolls R	oad Colu	mbia, Mary	land 21045
П			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caus cause on each	ed the death	n. Do not ente	r the mode of dying	, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		CA	akan	OVARUL	M Mais	nKit		Onset and Death
н	/Medical Examiner		resulting in death)	Due to (or a	as a consequ	uence of):	11 101/64	1100			A listings
Н		1	Sequentially list conditions, if any, leading to immediate causa. Enter University in	Duo to /or o	as a consequ						
	ted nsit	Examiner	Cause (Disease or injury	Due 10 (01 a	as a consequ	derice or):					
<u>,</u>	execun n and al-tra	Exai	that initiated events c. resulting in death) Last	Due to (or a	as a consequ	uence of):					
760,	ate be executed hysician and the burial-transit	call	d.								
89	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit										
Box	leath certific attending p	an/\	23b. Was decedent pregnant	c. If yes, outcom	ne of pregna		Ectopic pregnancy			23d. Date of deliver	егу
0	at the dea by the at tached fo	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant 9☐ Unknown	at time of de		Other (specify)			Month	Day Year
2	hat the deby		Part II. Other significant conditions cont	ributing to dooth	but not son	daine in all a constant	4-1-1		20 5:		
ecords,	w requires that been signed b should be deta	d by	Citron		_			n in Paπ I.		cco use contribute to t 2 ☑ No 3 ☐ Prot	ne cause of death?
Ö	v requ been shoul	etec	CANTONIC	"HOUR	1-11110	ין קיעון	~				
ě	The taw ate has page 2 s	Completed							24a. Was an autopsy performe	24b. Were auto prior to co death?	psy findings available mpletion of cause of
_		င်	25. Was case referred to medical						1 ☐ Yes 2		2 No
5	Phyaiclan: r this certific ral director,	O B	examiner?	spital:	tiont 2 🗆	ER/Outpatient			h (Check only one)		7
Ö	ding Phya h. After this funeral dis	n: T	27. Manner of Death	28a. Date of In	iury	28b. Time of	28c. Injury	at	28d. Describe how	ce 6 Other (Specification)	Hospica
0	tendin death. tor: Aft the fur	atio	1 Natural 5 Pending 2 Accident investigation	(Month, D	ay rear)	Injury	M 1 □ Y	es 2 □No			
IVISION	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of la	njury - At ho	me, farm, stre	et, factory, office	-	28f. Location (Stre City or Town,	et and Number or Rura State)	l Route Number,
2	italo insafi ral Di										
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	Z Medical Examinite	ir: On the basis	or examinati	wledge, death ion and/or inve	occurred at the time	, date and place, nion, death occurr	and due to the cau	se(s) and manner as st	ated.
	thin 2 the mple	Med	one) 29b. Signature and title of certifier	and manner s	stated.		29c. License				
	± ₹ 8		6/1/	//	_		M) c	22.7-	290	Date signed (Month,	vay, teat)
	d	1	30. Name and addr as of erso ratio com	pleted cause of	death /lto-	220) /7:	int)	747		1114 31,2	Cos
	0		OU. IVALITE AND AUGUS OF THE SOFT WHIO COM	pleted cause of	Land (Item	ZJa) (Type, P		/ daha	in m	10 1100	4
	Stat	e	31. Date filed (Month, Day, Year)	32. Regis	try's Signat	ure	-1-4/	- Marie v	ing "	U MON	/
1	Registra	ar 🐰	JUN 0 1	2005	Galera	11	Buch				

		1 - For State Registrar	State of Maryla		artment <i>rtificate</i>			Mental Hy	ygiene Reg. No.	005	1823
Physic	ian	1. Decedent's Name (First, Middle, L.	ast)					2. Date of D	eath		3. Time of Death
/Medi		Edward M.	Brady					May	30,	Year 2005	9:15PM
Exami	ner	4a. Facility Name (If not institution, gi	,		4b. City, To	own, or Lo	ocation of Dea	ith	4c. Co	inty of Deat	h
		Carroll Hospita					nster			Carr	
Funeral Director			1⊠M 2□F	s. last birthday) Yrs.			f Under 24 Hr Hours Mir	. (Month, O	ay, Year)	9. Birtl	nplace (State or Forei untry)
		Usual Residence of Decedent	74					Nov.	30,1930)	MD
72 hours after death with the Maryland natural', or Items 23a or 28a-f show disel Evan. or Itust be reditied at		10a. State 10b. County	10c. 0	City, Town or Lo	ocation						10d. Inside City Limi
the Mar 28a-f s	ţċ	MD Baltin	nore	Rei	istersi	town					1 ☐ Yes 2 X]N
vith the Maryla or 28a-f shot	Director	10e. Street and Number		1,00	10f. Zip C				10g. Citizen	of What Co	untry?
23a	ai	3 Mamopa Court				2113	16		T.	ISA	
rs atter death w I', or Items 23a	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Deceder			Specify Yes or N rto Rican, etc.)	0- 14.	Race - Amer	
P. I	by Fu	1 ☐ Never Married 2 ☑ Married	1 XYes 2 No If Yes, Give		1 ☐ Yes 2)			110 / 110 011, 010.7		Black, White ecify:	i, etc.
lural.		3 Widowed 4 Divorced	Year or Dates: 1948	- 52					Spe		hite
an in	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual (kind of work DO NOT use	done duri	on ing most of wo	orking	16b. Kind o	f Business/I	ndustry
r than "	mc	Elementary/Secondary (0-12)	College (1-4or 5+)			retirea)			_		
of the	Ö	17. Father's Name (First, Middle, Last	")	Sal	esman	18	R. Mother's Na	me (First, Middle		on To	ols
av d	To Be	Thomas Walter I	Produ			,,,				iame)	
th and Mental ?7 Is marked o traumatic ava	F	19a. Informant's Name/Relationship		19b Mailir	na Address /	Street and		Mae Moo		Ctata 7	i- O- d-)
ガマコ		Marlene E. Brady									p Code)
T 2 5		20a. Method of Disposition		Place of Dispo	sition (Name	of	, keis	terstowr Date	1 MD Z 20c. Locatio		own State
	١.,	1 ☑Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	21 IOIII OTA II OTII OTATO					16.105			
Department of Important: If any injury or once.	1	21. Signature 1 Funeral Service Lice		rrison	Forest Name and			/6/05			lls, MD
Depa Impo any ii		1 Carlon	MI Jak	/ 3 /			al Hom				town Road
6.		23a. Part1. Enter the disease, or com	plications that caused the dea							own, r	Approximate
ysician Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	24res		or aying, o	addir do dardio	o or respiratory a	irrosi,		Interval Between Onset and Death
aminer		1	Due to (or as a conse	. ,		1	8.				/ /
	i i	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	VO Vas	ruley	HCC	ident				1 day
nsit	Examiner	Cause (Disease or injury	500 to (5) as a conse	quence or).							,
al-tra	хаі	that initiated events resulting in death) Last	c Due to (or as a conse	quence of):							
physician and the burial-transit	dicai E										
phys ss the	edic		0.								
attending p I tor use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr						234	Date of deliv	on.
e atte	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		Ectopic pregi Other (speci					Month	Day Year
ed by the detached	hys	9 ☐ Unknown	9□ Unknown								
igned be det	by P	Part II. Other significant conditions of	ontributing to death but not re	sulting in the ur	nderlying caus	se given ir	Part I.	23e. Did t	obacco use co	ontribute to t	he cause of death?
07 77	pa							1 🗆 '	Yes 2□No	3 ☐ Prot	oably 4 Hhknown
as been 2 shouk	Completed							24a. Was	an 241	. Were auto	ppsy findings available
<u> </u>	mo								osy ormed?	prior to co death?	mpletion of cause of
certificate rector, pag	O)	25. Was case referred to medical				20	Place of Do	1 ☐ Yes ath (Check only o		1 🗆 Yes	2 100
is certific director,	ToB	examiner? 1 🗌 Yes 2 🔄 No	Hospital: 1 Inpatient 2] ER/Outpatien	3 DOA	Other		lome 5 ☐ Resid			
5 7	L:	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		Injury at Work?	4 🗆 Ivursing F	28d. Describe I			у)
Diractor: Aft	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury	М		2 🗆 No				
Diractor: After in by the funera	tifle	3 Suicide 6 Could not be determined	286. Place of Injury - At r	nome, farm, stre	et, factory, of	ffice		28f. Location (S	Street and Nur	nber or Rura	ıl Route Number,
0 -	Certification;	4 Homeldo	building, etc. (Speci	ny)				City or Tov	vn, State)		
To the Funeral C	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kniner: On the basis of examinating and manner stated.	owledge, death ation and/or inv	occurred at t	my opinio	late and place on, death occu	, and due to the cred at the time,	cause(s) and a	manner as si a, and due to	tated. the cause(s)
Mithir To th	Me	29b. Signature and title of certifier			29c. Li	icense nu	mber		29d. Date sigr	ned (Month,	Day, Year)
(1	1 hoces	Mo			1 50	2035		May	31	2005
1/	1	30. Name and address of person who	completed cause of death (Ite	m 23a) /Type 5	1						
		BINU CHACKE	291 Ston	es Ai	Muli.	Wen	tminis	H. 1	MD 21	157	
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign.			1 - 0.01	e susteriff.	101			
Registra		JUN	0 1 200 6	,							

DHMH 17 Rev 1/2001

EDWARD MOORE BRADY

ORIGINAL

			1- For State of Maryland / Department of He Registrar Certificate of D			ene200	5 18237
	Physici		Midstand A Rartaa Ir		2. Date of Death Month	Day Yea	
	/Medic Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or L	Location of Death	May 2	4c. County of De	
			Union Memorial Hospital Balto 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs.	P. Data of Birth	N/A	
	Funeral Director		217-40-5759 Usual Residence of Decedent	Hours Min.	8. Date of Birth (Month, Day, Y 7-13-1	943	Sirthplace (State or Foreign Country) Md
	ryland how		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	8a-fs	Director	Md N/A Balto				12 Yes 2 No
	with the or 2	Dire	10e. Street and Number 2426 W. Garrison Avenue	15	10g	g. Citizen of What (USA	Country?
	death	nera	12. Was Decedent Ever in U.S. 13. Was Decedent of His Armed Forces?		cify Yes or No-	14. Race - An	nerican Indian,
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "neturel", or Items 23e or 28e-1 show important: If item 27 ie marked other then "neturel", or Items 23e or 28e-1 show appring yor other treumatic event. The Medical Exercit art result is risilling at once.	by Funeral	1 Never Married 2 Married 1 Yes 2 No 1 Yes, Give Year or Dates:	Specify:	Hican, etc.)	Specify: B	
5-0	72 ho	eted	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done du	ion uring most of workin	16	6b. Kind of Busines	:s/Industry
Maryland 21215-0036	d within giene. er then "	Completed	Elementary/Secondary (0-12) 12th grade College (1-4or 5+) N/A Dispatcher	g		Taxi C	ompany
and	ld be file ental Hy ked oth c event	To Be (17. Father's Name (First, Middle, Last)	18. Mother's Name Laura T		iden Surname)	
Mary	12 shoul	F	19a. Informant's Name/Relationship (Type, Print) Maurice Bartee - Brother 19b. Mailing Address (Street and 3836 Terka Cin	nd Number or Rura	l Route Number, C	ity or Town, State,	, Zip Code)
	ss 1 and of Health item 27 other t		20a. Method of Disposition 20b. Place of Disposition (Name of	Į D		c. Location - City of	
Baltimore,	Page Iment c tant: If jury or		1 XBurial 2 □ Cremation 3 □ Removal from State '4 □ Infation 5 □ Other (Specify) King Memorial Park	k 6-2-2		andallst	own, Md
Bai	permit Depar Impor any in		21. Sizifature of Funeral Service Licensee 22. Name and Address	,	March F/		
	Pnysician	0 0	23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition				Md 21215 Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (as a consequence of):				
	₽ ≃	ner	Sequentially list conditions, Ill any Lead to immediate cause. Enter Underlying	Oicers			One month Seven days
Ć,	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Live Infection Due to (or as a consequence of):				Seven days
8760,	cate be physicia the bur	dicat	d				
Box 6	death certificate be executed e attending physician and id for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			23d. Date of de Month	elivery Day Year
<u>Р</u> О	at the de	Phys	9 ☐ Unknown 9 ☐ Unknown				
Records,	w requires that the been signed by the should be detache			in Part I.		1/23/	to the cause of death? Probably 4 □Unknown
	has b	Completed			24a. Was an autopsy performed	d? prior to death?	autopsy findings available completion of cause of
Vita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death		140	3 2 2 10
ō	Phys this al dii	. To	I Emparish 2 Elevoupation 3 Box	4 Nuising Hom	ne 5 Residence 8d. Describe how	e 6 Other (Spe	əcify)
ion	ttending death. ctor: After y the funer	atior	27. Manner of Death 1	s 2 No	od. Describe now	njury occurred	
Division of	after de Directo	ertification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28	8f. Location (Stree City or Town, S	t and Number or R itate)	Rural Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical C		date and place, ar	nd due to the caus d at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	withi To 1	3/	29b. Signature and title of certifier 29c. License n	38946-		Date signed (Mon.	
i	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	20140-	M	on, 27,	2005
1	1		Ali Esmaili, Union Memorial Hospital, 201 E.	Universit	ty Pernere	7. Bultin	nort, MD 21218
	Sta Registra	_	31. Date filed (Month, Day, Year) JUN 0 1 2005 32. Registrar's Signature		•		

			- State o			artment of H			-		JIDIC.	
			1 - For State Registrar	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		rtificate of l		.,	- 1	Reg. No.	Ub	18238
	Physici		1. Decedent's Name (First, Middle, Last)					2.	Date of Dea Month		Year	3. Time of Death
	/Medic		Lawrence William Banwor						May	22	2005	617 A M
	Examin	er	4a. Facility Name (If not institution, give street and nu			4b. City, Town, or	Locetion of	Death	- 1		ty of Death	n N
	Euporol		430 COOLEY MIL 5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year	If Under 2	4 Hrs. 8.	Date of Birti			
	Funeral Director		511-34-8938 ¹XM 2□F	64	Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day 1 / 05 / 1	, Year) 940	Kans	lace (State or Foreign try)
Pul	3		Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Lo	reation						0d. Inside City Limits
N N	1 eho	or	FL Marion								'`	1 ¥ Yes 2 □ No
d	r 28a	Director	10e. Street and Number	Oca	ıa	10f. Zip Code				10g. Citizen o	f What Coun	try?
the state of the s	23e o	al D	6458 S.W. 82nd Place			34476				USA		
2	lems in m	ner	Armed F	edent Ever in U.S. orces?	. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origi n, Mexican,	in? (Specify Puerto Rica	Yes or No- an, etc.)	14. Ra	ace - America ack, White, e	
36	l', or l	by Fi	If Vac G	2 □ No ive Dates: 1958-6		1 ☐ Yes 2 X No	Specify:			Spec		
d 21215-0036 filed within 72 hours after death with the Maryland	eture cal E	Completed by Funeral	15. Decedent's Education		16a. Dece	dent's Usual Occupa	ation			16b. Kind of		
215	e. Medin	npie	(Specify only highest grade completed) Elementary/Secondary (0-12) College ((Give life.	kind of work done of DO NOT use retired	during most o	of working				•
2 2	lygien her th	Con	12th		Pre	essman	10.11.1			Printin		mpany
Maryland	ed of	Be c	17. Father's Name (First, Middle, Last) Joseph Banworth							Maiden Suma	ume)	
	nd Me mark mativ	^C	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (Street a		_	lawkir		n, State, Zip	Code)
E Spar	Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or Items 23e or 28a-f ehow eny injury or other traumatic event, the Mcdical Examinar must be notified at ones.		Georgia Banworth- Wife			S.W. 82n						,
Baltimore,	of He if item or oth		20a. Method of Disposition 1 □ Burial 2 ★Cremation 3 □ Removal from	20b. Plac		sition (Name of natory or other place		Date		20c. Location	- City or Tov	wn, State
E E	tant: lant: jury o		` 4 ☐ Donation 5 ☐ Other (Specify)	R.A		rris & Co	1	5/24/0	-	lest Cl		
Bal	Depar Impor eny in		21. Signature of Funeral Service Licensee	10	N	Name and Address Nitchell-Si 23 S. Wa	s of Facility mith F	uner	al Hor	ne, P.	Α	
		-	29a. Part1. Enter the disease, or complications that	caused the death.							ace, M	ViD 21078 Approximate
D	hysician		shock, or heart failure. List only one cause on a Immediate Cause (Final	ach line.	o tes	. ^		0	de	to		Interval Between Onset and Death
•	Medical		disease or condition resulting in death) a. Due to	(or as a conseque	nce of):	Cardy	vaca	Nov	Urja	Pose		
Ε	xaminer		Sequentially list conditions b									
7 9	sit	Examiner	cause. Enter Underlying	(or as a conseque	nce of):							
xecute	sician and burial-transit	хап	Cause (Disease or injury that initiated events resulting in death) Last Due to	(or as a conseque	nce of):							
760, A	ysician he buriz	calE	d									
			u									
XO THE	attending pl	an/N	230. Was decedent pregnant	tcome of pregnanc		Ectopic pregnancy					ate of deliver	•
I Records, P.O. Box 68 The law requires that the death certifies	the at hed fo	Physician/Med		nant at time of deat		Other (specify)			-	M	lonth (Day Year
P. F.	igned by the a	Ph	Part II. Other significant conditions contributing to d	eath but not resulti	ing in the u	nderlying cause give	n in Part I		23e. Did to	pacco use cor	ntribute to the	e cause of death?
Records,	n sign	d by	Hypertension			,				s 2 No		bly 4 □Unknown
0 2 2 3	s been sig	olete	//					_	24a. Wasa	n 24b.	. Were autop	sy findings available
Re k	r this certificate has	Completed						_	autops perform	y	prior to com death?	pletion of cause of
	ertifica ictor, p	Bec	25. Was case referred to medical examiner?					of Death Cl	heck onl on	е		423 NO
of Vita	this or	္ရ	1 Yes 2 No Hospital: 1 □			t 3 DOA Othe	^{Ir:} 4 □ Nurs			ence 6 Ot		Scene
DIVISION Of VITAL	h. After funer	tion	Talifatal Servicing	th, Day Year)	8b. Time of Injury	28c. Injury Work	at ? ′es 2∐No		Describe ho	w injury occu	rred	
/ISI	after death. Director: A I in by the fa	fica	3 Suicide 6 Could not be	of Injury - At home	e, farm, str			28f.	Location (St	reet and Num	ber or Rural	Route Number,
	s after	Certification:	4 Homicide determined build	ing, etc. (Specify)					City or Town	n, State)		
DIVISION To the Hospiter or Attending	within 24 hours after d To the Funerel Direct completely filled in by		29a. Certifier (Check only (Ch	best of my knowle	edge, death	occurred at the tim	e, date and princes death	place, and	due to the ca	ause(s) and m	anner as sta	ited.
the characteristics and the characteristics are characteristics and the charac	the F	Medical	one) and man	ner stated.				00001100 2				
<u>و</u>	To		29b. Signature and title of certifier	MA AM	M.C.	29c. License	LL 7	6	2	9d. Date sign	eu (Month, D フィッ	ay, rear)
	100		30. Name and address of person who completed cause	se of death (Item 2	3a) (Tyna	Print)	TXU	0		" very o	X J, 4	ics
	140		BERNARD J. YUKNA,	MO DME	70	718 HOL	ABAGI	D AV	E. I	PALTO	Mcl	21222
	Sta			tegistrar's Signatur	o for	de						
	Registra	ar	JUN 0 1 2005	was so	Popular							

JET	
05-03706	5
Darrel1	E

		tte - State Unpend Item Registrar 1. Decedent's Name (First, Middle, I			Timodito of		2. Date of Death	3		3. Time of D	Death
hysici		Darrel1	Eugene	Ba	rnette		May 29	2005	Year	9:45	P^{λ}
/Medio xamir£		4a. Facility Name (If not institution, g				r Location of Deatl		4c. County		J	
-Adiiiii	Ŭ.	1109 W. Cross S	treet		Baltimo				N/A		
neral		5. Social Security Number 6	. Sex 7. Age	(In yrs. last birthday	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		Year)	9. Birthplac	e (State or	Foreig
ctor		220-90-5711 Usual Residence of Decedent	13111 221	36 Yrs.			March &	3,1969	Mary	Land	
-		10a. State 10b. County		10c. City, Town or I	Location				10d	. Inside City	y Limits
Na.	to	Maryland N/A	A	Balta	imore					1 Tes 2	2 🗌 No
any injury or other traumatic evant, the Medical Examiner must be notified at ODCs.	Funeral Directo	10e. Street and Number			10f. Zip Code		10	g. Citizen of W		?	
	ain	1109 West Cross	Street		21230				S.A.		
	nuel	11. Marital Status	12. Was Decedent E Armed Forces?		. Was Decedent of H If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puerl	Specify Yes or No- to Rican, etc.)		- American k, White, etc		
	y F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □Yes 2 ☑ 1 If Yes, Give Year or Dates:	0	1 ☐ Yes 2 ☑ No	Specify:		Specify	w	nite	
	Completed by	15. Decedent's	Education	16a. Dec	edent's Usual Occup	pation		6b. Kind of Bu			
	piet	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5	(Giv	edent's Usual Occup te kind of work done DO NOT use retire		rking	¥ 7	1		
	E O	9	N/A		Supervi	sor		war	ehous	e 	
	Be	17. Father's Name (First, Middle, La	st)	D	_	18. Mother's Nar linda	me (First, Middle, M	faiden Sumam	-	lt	
	은	Clarence		Barnette			(B + 11 + 1 + 1	0' · · T			
2		19a. Informant's Name/Relationship			iling Address <i>(Street</i> 09 West C1						230
	1	Linda Barnette 20a. Method of Disposition	(Mother)		position (Name of rematory or other pla			20c. Location -			
;		1 ■ Surial 2 □ Cremation 3 `4 □ Donation 5 □ Other (Spe	☐Removal from State		ross Cemet		4/05	Brookly	n Mar	yland	
GÓI		21. Signature of Funeral Service Lie									
once		1 Must	Collins.		McCully-po 130 East	Fort Ave.	. Baltimo	re mary	land :	21230	
		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused	the death. Do not e					A	oproximate iterval Betwe	veen
al i		Immediate Cause (Final disease or condition		Intoxica	tion				C	nset and De	eath
al		resulting in death)		a consequence of):	CIOII						
er		Sequentially list conditions,	b	0					_		
i	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence of):							
	Examiner	that initiated events resulting in death) Last	c Due to (or as a	a consequence of):							
	caiE		d								
101 and 201 an	edic		<u> </u>	-							
	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		B Ectopic pregnanc	v			of delivery	V	ear
	sicia	in the past 12 months? 1 Yes 2 No	4 ☐ Pregnant at 9 ☐ Unknown		Other (specify)			Mor	nth Da	ay re	eai
	Phy	9 Unknown Part II. Other significant condition	s contributing to death by	at not resulting in the	underwing cause of	ven in Part I	23e. Did tob	acco use contr	ibute to the	cause of de	eath?
en en ninnile z ef	by	Partii. Other significant condition	s contributing to death by	at not resoluting in the	andonying oddoo gi	on an i dict.	1 □ Ye	. /	3 Probab		
	Completed						24a. Was ar	24h V	Vere autops	v findings av	vailabl
Idiletal director, page 2	dmo						autops	ned? p	rior to comp leat/1?	oletion of cau	use of
		25. Was case referred to medical				26 Place of De	ath (Check only one		Yes 2	□ No	
	To Be	examiner?	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpat	ient 3 DOA		Home 5 ☐ Reside		er (Specify)	Scene	
	L.	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur Fourtd th, Day	y 28b. Time Found	/ Wo	ry at rk?	28d. Describe ho	w injury occurr	ed (ınk	
D	atic	2 Accident investiga	5-29-05	9:30	P [™] 1	Yes 2 No					
	Certification:	3 Suicide & Could no determin	ed 28e. Place of Inju- building, etc	ury - At home, farm, c. (Specily)	street, factory, office		28f. Location (Str City or Town	, State) 110	er or Rural F 9 W. (Route Numb Cross	St.
		47.0 47.1	Found at				Baltimore	e, Md			
0	Ca		Physician: To the best of xaminer: On the basis of and manner sta	examination and/or							
	777	29b. Sighature and title of certifier			29c. Licen:		29	d. Date signed	l (Month, Da	ry, Year)	
	Medical		A V	4 0 1 4	OCI	ΜE		May 30	200	5	
	Med	DIAL NO	Dhe Uh	UD M	W OO!		l l	יינ עובויין			
completely filled in b	Medi	30. Name and address of person w	ho completed cause of d		(V)		- XX		102	10	11
To the Funaral Director: . completely filled in by the f	Medi	30. Name and address of person w YAWA UTA 31. Date filed (Month, Day, Year)	f 1/ A -		(V)	nn Street	- XX	ore, Ma	102	10	01

ORIGINAL

-03642			State of Maryland / Den	artment of Health and	Mental Hygi	ene	
			State of Maryland / Department	rine G844 6-3-05	tas	g. No 0 0 5	18240
	Physicia	an	1. Decedent's Name (First, Middle, Last) Joseph Eugene Butler		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	May 27	2005 4c. County of Death	1219 A M
	Examin	er	Sinai Hospital	Baltimore	ui	N/A	
9	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birth	place (State or Foreign
9 0	Director	1	220-02-9618	Working Days Frours Will			cyland
land	A ti		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
Мал	a-f sh iffied	tor	Maryland N/A Balti	.more			XXYes 2□No
death with the Maryland	or 28 Pe not	Funeral Director	10e. Street and Number 1st Floor		10	g. Citizen of What Cou	ntry?
ath w	s 23a	srail	3801 Greenmount Avenue	21218		USA	
fter de	rhem	Fune	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	14. Race - Ameri Black, White,	, etc.
036 ours a	Exam	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 🔏 🛱 No Specify:		SpecifyBlac	ck.
5-0	"netu dical	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of wo	nrking 1	6b. Kind of Business/In	dustry
121 withir	then then	dmc	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) cruction Worke:	r Pr	ivate Ind	dustry
d 2	other	Be Co	17. Father's Name (First, Middle, Last)		me (First, Middle, M	laiden Sumame)	
/lar	Menta arked atic ev	To B	Thomas E. Butler, Sr.	Joyce 7	A. Speed		
Maryland 21215-0036	h and Mental Hyglene. 7 Is marked other then ". ireumatic event, Ir.e Mad		19a. Informant's Name/Relationship (Type, Print) 19b. Mailin Thomas E. Butler, Jr./Brother	ng Address (Street and Number or R	ural Route Number,	City or Town, State, Zip	Code) 77584
e , n	Health em 27 ther t		20a. Method of Disposition 20b. Place of Dispo			ear Land Oc. Location - City or To	
nor	ut: If it		cemetery, cred	psition (Name of matory or other place) 6/3 on AME Church	/ U.S	arks, Mary	
Baltimore,	Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Example of their treumatic event, Ir.e Medical Examinational bandified at once.			2. Name and Address of Facility C	hatman-H	arris Fur	neral Home
m a	Impo eny ir once		Deray Marie 52	240 Reistersto	wn Rd Ba	ltimore, N	
//	ysician Medical aminer		23a. Part: Enter the disease, or complications that caused the death. Do not enter speck, or head railure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Appendix Properties of the death		c or respiratory arre	st,	Approximate Interval Between Onset and Death
00, e executed	ohysician and the burial-transit	i Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):				
8760,		dicai	d				
vision of Vital Records, P.O. Box 6	y the attending proched for use as	by Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
s that	igned by the be detached	y Pt	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	acco use contribute to the	he cause of death?
ords equire	been sig should b	ted t			1 🗆 Yes	2 No 3 Prob	pably 4 Unknown
Vital Records, sicien: The law requires to	n. After this certificate has be funeral director, page 2 sh	Completed				ed? prior to co death? No 1 Yes	opsy findings available impletion of cause of
. Vii	s cert	To Be	25. Was case referred to medical examiner? 1	Othor	ath <i>Check onlone</i> Home 5□ Resider	ice 6 □Other (Specif	5.1
O C	n. After this funeral di	n: T	27. Manner of Death 28a. Date of Injury 28b. Time of		28d. Describe how		97
SiO	death. ctor: Af / the fur	catic	2 Accident investigation	M 1 Yes 2 No			
Division of	within 24 hours after deatr To the Funerel Director: completely filled in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stream building, etc. (Specify)	aet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rura State)	d Route Number,
Hospitel	Fune Fune stely fil	Medicai	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, deatl (Check only one) Medical Examiner: On the basis of examination and/or in and manner stated.	noccurred at the time, date and place vestigation, in my opinion, death occ	e, and due to the car urred at the time, da	use(s) and manner as s te and place, and due to	tated. o the cause(s)
To the	onthin Fo the comple	Med	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month,	Day, Year)
	Z F 0		Hote (Inon is fall)	OCME	1	May 27, 200	5
			30. Name and address of person who completed cause of death (Item 23a) (Type,				
			total Alan Day Vari	111 Penn Street	Baltimo	ore, Maryla	nd 21201
	Sta Registr	_	31. Date filed (Month, Day, Year) 32. Re-strar's Signature	park			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 **Physician** Year 25, CATHERINE BATTERDEN May 10:25A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 19,1909 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M Z\F Yrs. Director 215-05-4637 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10h. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madeal Examinations the notified at Baltimore Maryland Towson 1 Yes X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 Kenilworth Park Drive 21204 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Spacify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hyglene. 7 Ie marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Automobile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Tnomas Batterden Catherine Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21158 permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any injury or other traun once. James E Batterden Nephew 500 Pinehurst Circle Apt 103 Westminster Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XX Burial 2 Cremation 3 Removal from State ¹ 4 □ Donation 5 □ Other (Specify) New Cathedral Cemetery 5/28/05 Baltimore, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 21. Signature of Funeral Service Licensee Duni 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sepsis weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 4 □ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ neu 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence Other (Specify) Hospice 1 ☐ Yes 2 XNo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Injury 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No nours after death.

neral Director: A
filled in by the for investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral E 29a. Certifier 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one)

State Registrar

DHMH 17 Rev 1/2001

2

Baltimore, Maryland 21215-0036

of Vital Records, P.O.

Batterden,

JUN 0 1 2005 Januar & June

29b. Signature and title of gertifier

A

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of a (Item 23a) (Type, Print)

uns

ORIGINAL

6601 N. CHarles Street

29d. Date signed (Month, Day, Year)

25 2000

Towson, MD 21204

025205

			For Stata Registrar	State of Mar	yland /		rtment of h		and Mo		giene Reg. No.	200	5	1824	2
			Decedent's Name (First, Middle, Las	t)						2. Date of Dea	ath			3. Time of Death	Roset
	Physicia /Medic		ALICE MIDDLET	ON BOBIAN						Month O 5	27	Ŏ.	5	7130 A	М
	Examin		4a. Facility Name (If not institution, give				4b. City, Town, o	r Location o	f Death		4c.	County of D	eath		
			117 AVON BEACH RO				DUNDALK	-			E	BALTIM	ORE		
	Funeral		5. Social Security Number 6. S	□M 2KTE	in yrs. last b	Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birtl (Month, Day	v, Year)		Birthpla Count	ice (State or Forei	gn
	Director		214-38-3432 Usual Residence of Decedent		85	115.				MARCH 1	9,19	920		SC	
	land ow		10a. State 10b. County	1	Oc. City, Tox	wn or Loc	cation						10	d. Inside City Limi	ts
	Many I-1 sh	tor	MD BALTIMO	RE	TURN	VER S	STATION							1 XYes 2 □ N	lo
	n the	Funeral Director	10e. Street and Number				10f. Zip Code				10g. Citiz	zen of Whal	Count	y?	
	th wit	aiD	117 AVON BEACH RO)AD			212	222			Ι	JSA			
	ems errs	ıner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. V	Vas Decedent of H Yes, specify Cuba	lispanic Orig	gin? (Spec	cify Yes or No-	. 1	4. Race - A Black, W			
36	or it	y Fu	1 Never Married 2 Married	1 ☐ Yes ZXXNo If Yes, Give			☐ Yes 為☐XNo	Specify:		, , , , , ,	1	Specify:	riito, o		
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or items 23e or 28e-f show e Medical Exercit and be rediffed.	d by	3 Widowed 4 Divorced	Year or Dates:	100			-11				В	LAC		
<u>.</u>	in 72	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	168	(Give I	ent's Usual Occup k <i>ind of work done :</i> OO NOT use <i>retire</i> d	durina most	t of workin	g	16b. Kir	nd of Busine	ss/Indi	istry	
77	with iene. thar	mo	Elementary/Secondary (0-12)	College (1-4or 5+)			ACHER	-,			FT	UCATI	ON		
	Hyg other ent,	Be C	17. Father's Name (First, Middle, Last)			1111	CILLIC	18. Mothe	r's Name	(First, Middle,			OIN		_
an	lid be lenta rked tic ev	To B	OWEN MIDDLETON					LILL	IAN	GRANT					
Maryland	shou and N		19a. Informant's Name/Relationship (7	уре, Print)	19	b. Mailin	g Address (Street	and Numbe	r or Rurai	Route Numbe	r, City or	Town, State	э, <i>Zip</i> (Code)	
	and 2 paith a 27 i		CALVIN BOBIAN/SON	I		3510) FAIRVIE	EW ROA	D B	ALTIMOR	RE, M	IARYLA	ND	21207	
ore	of He of He fiterr		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □		20b. Place cemet	of Dispos ery, crem	sition (Name of natory or other place	ce)	Da	ate	20c. Lo	cation - City	or Tow	n, State	
Ĕ	Pag nent ant: I ury o		'4 □Donation 5 □ Other (Specify		HOLI	Y HI	ILL MEM.	GRD	6-3-	2005	BALT	IMORE	, M	ARYLAND	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depurtment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Exercit art and be notified a one.		21. Signature of Funeral Service Licen	500 M = F			Name and Addre								
ш	20599		James	y. Jon	MM	1	.701-31 I	AUREN	S ST	. BALT	HOM	E, MA	RYL	AND 2121	7
Г			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the one cause on each line.	e death. Do	not ente	or the mode of dyin	ng, such as	cardiac or	respiratory are	rest,			Approximate nterval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition	Cardio	reape	rah	sky all	ugt.						Driset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a c	consequence	0:							10	W.	
	LAGIIIIICI	_	Sequentially list conditions,	b. Pull to for as a c	NOON	M	reade						1	Uyw	
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Doe to (or as a t	consequence	9 01): =								O	
•	xecul and al-trar	xan	that initiated events resulting in death) Last	c. Due to (or as a c	consequence	e of):							-		
760,	cate be executed physician and the burial-transit	icai													
687	ficate p physics the	ed		d											-
Вох	leath certific attending pl	Ň/L	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of							2	3d. Date of	deliven	,	
m.	death e atte d for	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at tin			Ectopic pregnancy Other (specify)	<i>'</i>				Month		ay Year	
P. 0.	t the by the ache	Physician/M	9 Unknown	9□ Unknown										<u> </u>	
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by P	Part II. Other significant conditions of	ontributing to death but i	not resulting	in the un	derlying cause giv	en in Part I.		23e. Did to	bacco us	e contribute	to the	cause of death?	
Records,	w require been sig should b	ed	DIABetes							1 🗆 Y	es 2	(No 3□	Proba	oly 4 🗆 Unknow	m
ဝင္ပ	has be	ple	Hypentensi	M						24a. Was a		24b. Were	autops	y findings availab	le
	The ate h	Completed	Diverticula	win + An	emie	2				perfor		death 1 🗌 Y	?	□ No	
Division of Vital	Attending Physician: The Ir death. ector: After this certificate he ector: After this certificate he	Be (25. Was case referred to medical examiner?							(Check only or					
>	hysic his ca	2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient				er: 4 🗆 Nui	rsing Hom	ne 5 X Resid	ence 6	Other (S	pecify)		
בַ	ing P	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	'ear) 28b.	Time of Injury	28c. Injun Wor			8d. Describe h	ow injury	occurred			
Sio	tendi leath tor: A	cati	2 Accident investigation 3 Suicide 6 Could not be					Yes 2 N							
\leq	l or At after d Direct I in by	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (- At home, f (Specify)	farm, stre	et, factory, office		21	8f. Location (S City or Tow		Number or	Rural	Route Number,	
	pital ours a eral [20a Cortifier 1 Cortifuing Ph	veicing: To the best of	mu knowlodo	an doath	annumed at the time	no data an	d alace of	and divin to the co					
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Madical Examone)	ysician: To the best of a liner: On the basis of ex and manner state	kamination a	nd/or inv	estigation, in my o	pinion, deat	n piace, ai	d at the time, o	date and	and manner place, and d	as sta lue to t	ed. Te cause(s)	
	o the	Me	29b. Signature and title of certifier	and married state			29c. Licens	e number		2	29d. Date	signed (Mo	onth, D	ay, Year)	
)	F S F Ö		Mill as to 18	Lunda			D210	91			DE	1211	16		
1	10		30. Name and address of person who	completed cause of dear	th (Item 23a)) (Type, F	Defeat)				UJ	10,10			
1	Ų		Willarda Ed	wards	100	5	North	p.+. 3	Bluc	1. Dur	relal	K. M	· 4	21222	
	Sta		31. Date filed (Month, Day, Year)	32. egistrar's	Signature	A	and s								
	Registr	ar	2018 (1 T S)	105 Alexan	1 15	M	No William								

		•	For State 1 - State Registrar	e of Maryland / Depa	rtment of h		ental Hygien		
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last) ALT ETA 4a. Facility Name (If not institution, give street an	AUM STEIR			may a	Year 2065	3. Time of Death
	Funeral Director	er	NORTHWEST HOSPITAL CE 5. Social Security Number 116-09-9207 This is a security Number of S. Sex	NTER 7. Age (In yrs. last birthday)	RANDALL If Under 1 Year Months Days	.STOWN	1/	BALTIMORE	elace (State or Foreign httry)
	e Maryland	ctor	Usual Residence of Decedent 10a. State 10b. County MD BALTIMORE	10c. City, Town or Lo	cation	BALTIMORE			0d. Inside City Limits 1 ☐ Yes 2 ☑ No
•	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23e or 28e-f show event, the Medical Examinar must be notified at	Funeral Director	1 ☐ Never Married 2 💢 Married 1 💢	Decedent Ever in U.S. ed Forces? Yes 2 □ No WWII		21208 lispanic Origin? (Speci an, Mexican, Puerto Ri		14. Race - Americ Black, White,	USA an Indian,
215-0036	ithin 72 hours a ne. nen "natural", o Medical Ezar	Completed by	3 Widowed 4 Divorced If Ye Year 15. Decedent's Education (Specify only highest grade completed in the complete in the complet	s, Give or Dates: 16a. Decec (Give life. Life)	OO NOT use retired	during most of working		Specify: Kind of Business/Inc	WHITE
nd 2	be filed stal Hygi od other event, I	To Be Cor	17. Father's Name (First, Middle, Last) HYMAN	BAUMS		18. Mother's Name (First, Middle, Maide		SOMBERG
	s 1 and 2 s if Health ar item 27 is other treu		19a. Informant's Name/Relationship (Type, Print MIRIAM W. BAUMSTEIN 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 ☑ Removal is	/ WIFE 725 N 20b. Place of Dispos	MT. WILSO	and Number or Rural I ON LANE #20 (ce) PARK	8 - BALT		21208
Baltimore,	permit. Page Department o Importent: If any injury or once.		14 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	BETH ISRA	. Name and Addre	ERSTOWN RO	LEVINSON AD - PIKE	& BROS.,	INC. MD 21208
	hysician /Medical Examiner			hat caused the death. Do not enter on each line. Here Sclendt e to (or as a consequence of):	er the mode of dyin	ng, such as cardiac or i	respiratory arrest, CULAV (disease	Approximate Interval Between Onset and Death
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	e to (or as a consequence of):					
ox 68760	hys ate		IF FEMALE: 23c If year	s, outcome of pregnancy					
P.O. Bo	res that the death isigned by the attent be detached for u	Physician/Medicai	in the past 12 months?	ive birth 2 ☐ Fetal death 3 ☐ Pregnant at time of death 5 ☐ Jnknown	Ectopic pregnancy Other (specify)		23a. Did tobacco	23d. Date of delive Month	Day Year
Vital Records,	The law requires that the death certific atte has been signed by the attending page 2 should be detached for use as t	Completed by	Deep venus throng	tosis, polya	themi	g verg		2 No 3 Prob	ably 4 Unknown osy findings available npletion of cause of
		To Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ We Hospital: 27. Manner of Death 28a. I	1 Unpatient 2 EP/Outpatient Date of Injury Month, Day Year) 28b. Time of Injury	3 □ DOA Oth	4 Nursing Home	1 Yes 2 N	6 ☐ Other (Specify	2 No
Division of	To the Hospitel or Attending Physicien: within 24 hours after death as a few death To the Funerel Director: After this certifica completely filled in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	Month, Day Year) Injury Place of Injury - At home, farm, stre- building, etc. (Specify)	M 1 🗆	k? Yes 2 ☐ No		and Number or Rura	l Route Number,
	To the Hospitel or within 24 hours after To the Funerel Discompletely filled in	Medical C	(Check only 2 Medical Examiner: On t	o the best of my knowledge, death he basis of examination and/or inv manner stated.	29c. License	pinion, death occurred number	at the time, date an	ate signed (Month, i	the cause(s)
3	01	/	Dangerape 30 Name and address of person who completed Connections I	Cause of death (Item 23a) (Type, I	Print) N	4288 Attwes	- Hon	vay 2)	7200 ·

State Registrar

amend item#25,27 perME, G843,6/1/05 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 24 2005 Walter G. Chiavacci /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

The Hours | Min. | 75 | 19 AS CALTHCARE Nes Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 2 M 2 □ F May 25, 1911 93 Yrs. Director 196-01-9495 Italy Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or itame 23s or 28s-f show the Medical Examiner must be nutified at 1 ☐ Yes 25 No Maryland Baltimore Catonsville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 112 Taunton Avenue 21228 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Steel 6 Steel Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pio Chiavacci Pages 1 and 2 should Allessandrina Chiappelli and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Heatth ar
important; if itsm 27 is
eny injury or other trau 112 Taunton Ave. Catonsville, MD 21228 Walter P. Chiavacci (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5-27-2005 Baltimore, Maryland *4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 22. Name and Address of Facility Witzke Funeral Home of Catonsville, 1630 Edmondson Ave. Catonsville, MD 21. Signature of Fundial Service Licenses 1101290 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NEUMONIA Physician WEEK /Medical Due to (or as a consequence of) Examiner FIGATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transli Due to (or as a consequence of) Box 68760. Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ned by the atter in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign 1 be 1 Yes 2 No 3 Probably 4 Onknown FRACTURES page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 1 ☐ Yes 2 ☐ No 20 No 1 Yes Division of Vital Be 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2€1100 Medical Certification: To 28a. Date of Injury
(Month, Day Year)

28b. Time of Injury
Wo
1

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28d. Describe how injury occurred 27. Manner of Death After 1. Natural DASSENGER IN AMBULANCE 5 Pending investigation 1 ☐ Yes 2 the death. 2XXAccident after death Director: the 3 Suicide 4 Homicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

AMDO. L'i Fe STAN # 138 CATONEVILLE

M. A. determined filled in by Street within 24 hours a To the Funeral C completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 10051865 Herles 18 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES AGNES CURTIS 57 MOSP ITM 31. Date filed (Month, Day, Year) 32. Registrans Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Midgle, Last) 2. Date of Death MAY **Physician** MARIAN 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. oward oward Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2**Æ**F Yrs Director 220 24 4319 Maryland Usual Residence of Decedent Pages 1 and 2 should be lifed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23s or 28e-f show ury or other traumatic event. In Medical Examinat must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Director MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2413 Mt. Hebron Drive 21042 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ Specify 3€ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Owner Antiques 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel Healey Agnes Brady 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick H. Crowe Jr./Son 3410 Jay Drive Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If i any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 6-4-2005 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 0 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NEUMONIA Physician /Medical **Examiner** MUEMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner MALLAND LARGE BONEIS attending physician and for use as the burial-transit requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by lunongre Obstructur D (Seast 1 Yes 2 No 3 Probably 4 Denknown RITONITIS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has page 2 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 29 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dire ို 1 🗌 Yes 1 npatient 3□ DOA 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Certification: 1 WNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

And manner as stated. 29b. Signature and tith 29d. Date signed (Month, Day, Year)

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

30. ARMORY PL: Suite 3.6

Unknown 05-03586		.d	Edwin Coates Please Ty	pe or Print	in Black Inc	delible Ink.	Ensure All	Copies	Are Leg	gible.		
crn		•	For State Registrar	State of Mar	-	artment of F	lealth and Mo Death		giene Reg. No.	05	1824	16
	Physicia	an	Decedent's Name (First, Middle, Last) Donald Edwar	rd . C	oates	III		2. Date of Dea Month May	Day 24	2005	3. Time of 0	Death ${ m P}^{ m M}$
	/Medic Examin		4a. Fecility Name (If not institution, give street 100 Block W. Ordnati	eet and number)		4b. City, Town, o	r Location of Death Burnie			nty of Death Le Arun	ide1	
	Funeral Director		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday) O Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 9 4	h y, Year) 1984		lace (State or try) ID	Foreign
ryland	show 1.11		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo					10	0d. Inside City	
the Ma	r 28a-f s rnotifie	Director	MD N/A 10e. Street and Number		Baltin	10f. Zip Code	1		10g. Citizen o	of What Coun		
ath with	9 23a o	raiD	2700 Berea Road		in in It S	21225	lispanic Origin? (Spe	oify Vac or Na		SA ace - Americ	an Indian	
d 21215-0036 filed within 72 hours after death with the Maryland	"naturel", or iteme 23a or 28a-f show olicel Examinat must be notified at	by Funerai	11. Marital Status 12 1 XNever Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	,	f Yes, specify Cuba 1 ☐ Yes 2 🕱 No	an, Mexican, Puerto F	Rican, etc.)		lack, White,		
5-00	"nature	eted	15. Decedent's Educa (Specify only highest grade of	tion	(Give	dent's Usual Occup kind of work done	during most of workir	ng	16b. Kind of	Business/Ind		
21215-0036	al Hygiene. I other then vent, Ine Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+N/A)	no not use retired aborer				ious		
Maryland	lental Hyg kad othe ilc event,	To Be (17. Father's Name (First, Middle, Last) Donald Co	oates J	r.		18. Mother's Name	(First, Middle, Orah	Maiden Sum Bell	ame)		
Mary 12 shou	of Health and Mental H litem 27 is marked of r other traumatic ever		19a. Informant's Name/Relationship (Type Norman Aarons, Jr.		050	ng Address (Street 6 Spellma	and Number or Rura.	Route Numbe		m, State, Zip 2122		
nore, I	Department of Healt Important: If Item 2 any injury or othar once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Rer		20b. Place of Dispo	esition (Name of matory or other place	ce) D	ate 005		n - City or To)
Baltimore,	Departme Important any injury once.		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 		22	2. Name and Addre	ess of Facility M	ARCH FU	NERAL	HOME-E		
P	nysician /Medical xaminer		23a. Part1. Enter the disease, or complict shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, b.	Due to (or as a	he death. Do not end consequents of):		North Avening, such as cardiac o		altimor	e, mD	212C Approximate Interval Betw Onset and D	veen
68760,	attending physician and for use as the burial-transit	edicai Examine	Sequentially list conditions, it my, tearing to ammodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.		consequence of):							
Box	baen signed by the attending should be detached for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	y			Date of delive Month		'ear
rds, P.	n signed by	þ	Part II. Other significant conditions conti	ibuting to death bu	t not resulting in the u	inderlying cause gr	ven in Part I.	23e. Did to	obacco use co Yes () No		ne cause of de pably 4 Du	
al Reco	certificate has baerector, page 2 sho	Completed	25. Was case referred to medical				26. Place of Death	Yes	rmed? 2□No	death?	psy findings a mpletion of ca 2 No	vailable tuse of
Division of Vital Records, P.O.	one most need to the form of the confiction of the completely filled in by the funeral director, page completely filled in by the funeral director, page	ledical Certification; To Be	eyaminer?	building, etc.	year) 28b. Time of Injury 1853 ry - At home, farm, st (Specify) 57724 f my knowledge, dead examination and/or in	f 28c. Inju Wo Teet, factory, office	her: 4 Nursing Hor ry at ry k? Yes 2 TNo	Residue 5 Residue 128d. Describe 128f. Location (City) Tow	tence 6 XIC thow injury occ Street and Num, State) cause(s) and	ourred Hy mber or nura Onle manner as s	clice al Route Numb well tated. 21	ber,
	within 2 To the comple	Mec	29b. Signature and title of certifier	U. J.	the far	OC	se number ME		29d. Date sig			
2			30. Name and address of pyrson who con J. L. Locke 31. Date filed (Month, Day, Year)	- M.D.	r's Signature	111 Pe	nn Street	Balti	more, I	Maryla	nd 2120	D1 ———
	Sta Regist	ate rar		1 2005	Mogros D	: Sperk						

ORIGINAL

State Registrar

ORIGINAL

ss of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

wike,

31. Date filed (Month, Day, Year)

OCME

111 Penn Street

May

31

Baltimore, Maryland 21201

Registrar

JUN 0 1 2005

ORIGINAL

ADH THOMAS CASH 05-3729

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

149			For State Registrar	State of Ma	ryland / Depa	artment of F			ene	1824	9
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, L Thomas 4a. Facility Name (If not institution, g	ive street and number)	Cash		or Location of Death	2. Date of Death Month MAY	Day Year 31, 2005 4c. County of Death	3. Time of Dea 0653	A M
	Funeral Director		HARBOR HOSPITAI 5. Social Security Number 6. HARBOR HOSPITAI 6. HOSPITAI 6. HOSPITAI 6. HOSPITAI 6. HOSPITAI		(In yrs. last birthday)	BALTIMO If Under 1 Year Months Days	RE CITY If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	N/A (950 N. Ca	place (State or For	reign
	Maryland e-f show	ctor	10a. State 10b. County NA NIA		10c. City, Town or Lo Baltimor					10d. Inside City Lin	
	death with the Maryland ms 23a or 28e-f show rinust be polified at	Funeral Director	10e. Street and Number 3034 Maisbury	Ct.		10f, Zip Code)	u	g. Citizen of What Cou		
5-0036	hours after de tural', or Itami	by	11. Marital Status 1. Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 WYes 2 N If Yes, Give Year or Dates:	0	Was Decedent of Hif Yes, specify Cub.	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Bla		
21215-(s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if Health and Mental Hygiene item 27 is marked other than "natural", or Itams 23a or 28e-1 show other traumatic event, I'm Medical Explorate invaling the political at	Completed	15. Decedent's (Specify only highest g		(Give	dent's Usual Occup kind of work done DO NOT use retire	oation during most of work d)	ing	6b. Kind of Business/In	,	
Maryland	2 should ba file n and Mental Hy ls marked oth raumatic event	To Be (17. Father's Name (First, Middle, La James T. Cas	7			Fannie	e (First, Middle, M Smith			
	es 1 and 2 sh of Health and fitem 27 Is m r other traum		Fannie Cash - m 20a. Method of Disposition	other	1010	W Baltin	more St.	Apt. 706	City or Town, State, Zip. Bolto M. Oc. Location - City or To	D 7127	3
Baltimore,	permit. Page Department o Important: If any injury or once.		1 Burial 2 Cremation 3 4 Donation 5 Other (Special Service Life Control of the Control of Control	eity)	Gornson	Forest		-05 0	wings Mil	Is, MD	
	Pnysician /Medical		23a. Park. Ener the glease, or co shock, or heart failure. List on Immediate Couse (Final disease or Andition resulting in death)	a.ARTERIOSC	the death. Do not enter. LEROTIC CA. consequence of):	ter the mode of dyir	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death	n h
8760,	ate be executed by sician and he burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as a	consequence of);						
.O. Box 68	death certific e attending p id for use as t	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	Fetal death 3	Ectopic pregnanc	у		23d. Date of delive Month	ery Day Year	
Δ.	sign d be	by	Part II. Other significant conditions	contributing to death bu	t not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba	acco use contribute to t	-	1
Vital Records,	The law ate has b page 2 sl	Completed						24a. Was an autopsy perform	ed? prior to co	psy findings avail mpletion of cause 2 No	lable e of
ō	Attsnding Physicien: Thr death. ector: After this certificate by the funeral director, pag	To Be	25. Was case referred to medical examiner? 1 X Yes 2 No 27. Manner of Death latural 5 Pending investigat	Hospital: 1 Inpatier 28a. Date of Injun (Month, Day)	/ 28b. Time o	f 28c. Injui	ner: 4 🗌 Nursing Ho	h (Check only one ome 5 Resider 28d. Describe how	ice 6 □Other (Specii	iy)	
Division	To the Hospitel or Attsndi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At home, farm, st. (Specify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,	
	To the Hospitel or At within 24 hours after o To the Funerel Directompletely filled in by	edical	(Check only 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner state	examination and/or in	vestigation, in my	opinion, death occur	red at the time, dat	te and place, and due to	o the cause(s)	
	vith con	Σ	29b. Signature and title of certifier	em		29c. Licens	se number ME		d. Date signed <i>(Month,</i> $UNE 1, 200$		
	6		30. Name and address of person who	o completed cause of de	ath (Item 23a) (Type,	III Pen	n Street	Baltimo	re, Marylar		
	Sta Registi		31. Date filed (Month, Day, Year)	N 0 1 2005 istra	r's signature	y Spark					

			. For	State of M						•	-	Die.	
		ľ	1 - State Registrar			Cei	rtificate c	of Death			g. No.?	05	18250
П	Physicia	an	1. Decedent's Name (First, Middle, La	ast)	0					Date of Death Month	Day	Year	3. Time of Death
	/Medic	al	Rudolph 4a. Facility Name (If not institution, gi	un etmot and number	ک	astagne		n, or Location	of Doath	May 28,	2005 4c. County	of Doath	5:00 A M
	Examin	er	Stella Maris - To				_		OI Dealli		_	imor	
	Funeral		5. Social Security Number 6.	Sex 7. Ac	je (In yrs.	last birthday)	If Under 1 Ye		r 24 Hrs.	8. Date of Birth			place (State or Foreign
П	Director		210-07-7201	1 X M 2□F		35 Yrs.	Months Da	ys Hours	Min.	B. Date of Birth (Month, Day, July 22,	1919	PA	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation					1	Od. Inside City Limits
	Maryl f sho	jo	MD Baltimo	ore		Dunda	1k						1 ☐ Yes 2 No
	death with the Maryland ims 23a or 28a-f show	Director	10e. Street and Number				10f. Zip Cod	е		10	g. Citizen of \	What Cour	ntry?
	23a c	alD	2903 Dunran Road	Apt B			212	22			USA		
	tems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		J.S. 13.	Was Decedent	of Hispanic Or Cuban, Mexica	rigin? (Sp <i>ec</i> ın, Puerto R	ify Yes or No- ican, etc.)		e - Americ ck, White,	can Indian, etc.
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 Yes 2 If Yes, Give Year or Dates:	No		1□Yes 2X	No Specify	:		Specify	· Whi	te
9	be filed within 72 hours after ital Hygiene. Id other then "natural", or Ital other then "natural", or Italies event, the Medicul Examina.	ted	15. Decedent's 8	ducation		16a. Dece	dent's Usual Oc	cupation	-1-1	11	6b. Kind of B	usiness/In	dustry
215	thin 7 e.	Completed	(Specify only highest gi Elementary/Secondary (0-12)	College (1-4or	5+)	life.	kind of work do DO NOT use re	ne auring mos tired)	st or working	9			
2	led wi lygien her th		10 years			Chem	ical An		. d. N	/F: 15:-1-11 15	Stee		
ano	ntal Hed of	Be	17. Father's Name (First, Middle, Las						y Celo	(First, Middle, Mi	aiden Suman	10)	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. and Mental Hygiene is merked other then "natural", or Items 23a or 28a-f show eumatic event, it a Medical Exame meticulation and an entire of the medical and an entire of the entire of the medical and an entire of the medical and an entire of the medical and an entire of the	٦	Joseph Castagnera 19a. Informant's Name/Relationship			19b. Maili	ng Address (Str			Route Number,	City or Town,	State, Zip	Code)
	s 1 and 2 should f Health and Men item 27 is marke other treumatic		Ronald Castagnera		า					Edgemere			
Sre,	os 1 and of Health fitem 27		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 [Domoval from State	20b.	Place of Dispo	sition (Name or natory or other	place)	Da	ite 2	0c. Location -	City or To	own, State
Ĕ	Pages ment of ent: If it ury or o		'4 □Donation 5 □Other (Spec		Bay		remator						ity, MD.
Baltimore,	permit. Pages Department of Importent: If i eny injury or once.		21. Signature of Funeral Service Lice	Conne	lle	7	onnelly 110 Sol	r Funer Lers P	al Hor	me Of Du Road, Du	ındalk, ındalk,	P.A.	21222
			23a. Part1. Enter the disease, proor shock, or heart failure. List only	nplications that cause one cause on each i	d the dea					respiratory arres			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. LUNG CA	NCER	Ł						Į	Onset and Death
	/Medical- Examiner		resulting in death)	Due to (or as	a consec	quence of):							
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consec	quence of):				·-			
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	6									
,09/	te be executed ysicien and e burial-transit	Еха	resulting in death) Last	Due to (or as	a consec	quence of):							<u> </u>
,		lical	,	d									
x 68	leath certificate t attending physic I for use as the E	/Mec	IF FEMALE:	23c. If yes, outcome	of pregn	anny							
Вох	atten for us	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Feta	al death 3[Ectopic pregna Other (specify					te of delive inth	Day Year
o.	that the de led by the a detached i	hysl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown									
S, D	gn gn	by Physician/Med	Part II. Dther significant conditions	contributing to death t	out not res	sulting in the u	nderlying cause	given in Part	1.				ne cause of death?
Vital Records,	w require been sign	Completed								1 Yes	2 No	3 Prob	ably 4XJUnknown
ě	has b	nple								24a. Was an autopsy performe		Were auto prior to co death?	psy findings available mptetion of cause of
a	n: The icate r, pag									1 Yes 2	XNo	1 Yes	2 No
Ž	sicien: The law certificate has b irector, page 2 s	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2▼ No	Hospital:	ant 2	ER/Outpatier	nt 3 DOA	Othor		<i>(Check only one)</i> e 5 ☐ Residen		os (Consid	HOODEGE
10	g Phy er this ieral d	n; To	27. Manner of Death	28a. Date of Inju	JIV	28b. Time o		njury at Work?		3d. Describe how			HOSPICE
0	endin sath. or: Aft he fur	atlo	1 X Natural 5 ☐ Pending investigation	on	, , , , ,	injury .		Yes 2]No				
Division of	after de Directe d in by t	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		jury - At h tc. <i>(Speci</i>	nome, farm, sti ify)	reet, factory, offi	сө	28	Bf. Location (Stree City or Town,		er or Rura	I Route Number,
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical C		hysician: To the best miner: On the basis of and manner st	f examina								
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier)			29c. Lic	ense number		290	d. Date signe	d (Month.	Day, Year)
				12-			10	1437	125		51	31/	05
6	1		30. Name and address of person who										
1)	· .	DR. TARIQ MAHMO 31. Date filed (Month, Day, Year)	OD 2300 D 32. Regist	rar's Sign	aturo	LEY RD.	TIMO	NIUM,	MD 2109	3		
: 3	Sta Registr		11. Date med (Nonin, Bay, 16a)	1	· · ·	Aces	E)						

5:00 а.ш.

MAY 28, 2005

RUDOLPH CASTAGNERA

		State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2005 82									
		Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	3. Time of Dea		
Physic		MACK	- MAI								
/Med Exam		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of Deat	h	4c. County	of Death		
		JUHNS HUDILINS	BAYVIEW		BAUTI						
Funera	al		Sex 7. Age ((In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	th y, Year)	Birthplace (State or Fo. Country)		
Directo	r	239-32-2300	125 M 2 U F	67 Yrs.			October	22,1937	NC.		
pu 🔻		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Li		
lanyli sho	5	MD_{\bullet} N/A	4	Balti	more				1X Yes 2□		
he N	Director	10e. Street and Number			10f. Zip Code		10g. Citizen of What Country?				
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinat must be rediffed at once.	급	1401 Bonsal Street			21224	1	_	USA			
	Funeral		12. Was Decedent Ev	er in U.S. 13	Was Decedent of Hi	ispanic Origin? (S	Specify Yes or No		e - American Indian,		
	S	11. Marital Status 1 ☐ Never Married 2X Married	Armed Forces? 1 ☐ Yes 2 📉 No		If Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)	Blac	ck, White, etc.		
	by F	3 Widowed 4 Divorced		1□Yes 2X No	Specify:		Specify	Specify:White			
hou stura	ed	15. Decedent's E		16a. Dece	dent's Usual Occupa	ation	alita a	16b. Kind of Bu	usiness/Industry		
in 72	Completed	(Specify only highest gr	ade completed) College (1-4or 5+	life.	kind of work done of DO NOT use retired	during most or wo	rking				
nd 2 should be filed within 72 hours aft lith and Mentat Hygiene. 27 is marked other than "natural", or rtraumatic event, the Medical Exami	E	Elementary/Secondary (0-12) 12 years	College (1-401 54)		cklayer			Constru	uction		
filed Hyg other	BeC	17. Father's Name (First, Middle, Last	t)			18. Mother's Na	me (First, Middle	, Maiden Suman	10)		
d be enta ked	To B	William Alsie Car	rter			Kathl	een Summ	erlin	lin		
shou nd M mar mar	—	19a. Informant's Name/Relationship		19b. Maili	ing Address (Street	and Number or R	ural Route Numb	er, City or Town,	State, Zip Code)		
od 2 lift a 27 is		Lonnie Carter	Brothe	r P.O.	Box 45, I	Benson, 1	MD. 2101	8			
Hea Hea tem othe		20a. Method of Disposition		20b. Place of Disp	osition (Name of matory or other place	(a)	Date		City or Town, Stete		
ages ant of it: If i		1 Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Speci			Cemetery	June	1,2005	Dundall	k,MD.		
it. Partamentant	à	21. Signature of Funery Service Lice		2	2. Name and Addres	ss of Facility	Of	Dundlale	D 3		
permit. Pages 1 a Department of Hes Important: If item any injury or othe		Mus m	ella h	1	7110 Solla	runeral	HOME OI	Dundalk	Md. 21222		
Pnysicial /Medica Examine	al er	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Sequentially list conditions, Location 12 immediate cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
e executed ian and urial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a				-				
death certifi e attending I od for use as	dicai	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	Due to (or as a	consequence of): If pregnancy Fetal death 3	□Ectopic pregnancy	,		1	te of delivery onth Day Year		
death certific e attending p od for use as	dicai	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a c. Due to (or as a d. 23c. If yes, outcome of the control of	consequence of): If pregnancy Fetal death Sime of death	Other (specify)		23e Did	Mo	onth Day Year		
hat the death certific od by the attending p detached for use as	by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significent conditions	Due to (or as a c. Due to (or as a d. 23c. If yes, outcome o 1	f pregnancy	Other (specify)	ven in Part I.		tobacco use conf	onth Day Year		
hat the death certific od by the attending p	by Physician/Medical	COVONDMY AMBON	Due to (or as a c. Due to (or as a d. 23c. If yes, outcome o 1	f pregnancy	Other (specify)	ven in Part I.	1)2	tobacco use conf	onth Day Year tribute to the cause of deatl 3 Probably 4 Unkr		
hat the death certific od by the attending p	oleted by Physiclan/Medical	COVONDMY AMBON	Due to (or as a c. Due to (or as a d. 23c. If yes, outcome o 1	f pregnancy	Other (specify)	ven in Part I.	24a. Was	tobacco use confi	onth Day Year		
hat the death certific od by the attending p	oleted by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significent conditions CONDIANY ANDMY HISTORY OF ALLOW 25. Was case referred to medical	Due to (or as a c. Due to (or as a d. 23c. If yes, outcome o 1	f pregnancy	Other (specify)	ren in Part I. FAI LWN.E	24a. Was	tobacco use conf Yes 2 □ No s an pby pomed?	tribute to the cause of death 3 Probably 4 Unknown autopsy findings avaigned to completion of causticeath?		
hat the death certific od by the attending p	o Be Completed by Physiclan/Medical	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significent conditions CONONAMY AMBLY HISTOMY OF ALCOH	Due to (or as a c. Due to (or as a d. 23c. If yes, outcome o 1 Live birth 2 4 Pregnant at t 9 Unknown contributing to death but	f pregnancy Fetal death 3 ime of death 5 t not resulting in the	Other (specify)	ren in Part I. FALLWUE 26. Place of De	24a. Was auto perf 1 \(\text{Yes}	Mo tobacco use cont Yes 2 □ No s an psy ormed? 2MNo one)	onth Day Year tribute to the cause of deatl 3 Probably 4 Unkr Were autopsy findings avail prior to completion of causi death? 1 Yes 2 No		
Physician: The law requires that the death certific trins certificate has been signed by the attending priral director, page 2 should be detached for use as	To Be Completed by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significent conditions CONDUMNY AND MEMORY 25. Was case referred to medical examiner? 1 Yes 2 No 9 Due to (or as a c. Due to (or as a d. 23c. If yes, outcome o 1 Live birth 2 4 Pregnant at t 9 Unknown contributing to death but	f pregnancy Fetal death 3 Fetal death 5 Interest the control of th	Other (specify)	26. Place of Defer. 4 Nursing	24a. Wa autoper 1 Yes eath (Check only Home 5 Res	Mo tobacco use cont Yes 2 □ No s an psy ormed? 2MNo one)	onth Day Year tribute to the cause of deatl 3 Probably 4 Unkr Were autopsy findings avail prior to completion of causi death? 1 Yes 2 No			
Physician: The law requires that the death certific trins certificate has been signed by the attending priral director, page 2 should be detached for use as	To Be Completed by Physiclan/Medical	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a c. Due to (or as a d. 23c. If yes, outcome of the contribution of	f pregnancy Fetal death 3 Fetal death 5 Interest the control of th	underlying cause giv UE HEAM ent 3 DOA Other	26. Place of Defer. 4 Nursing	24a. Waraute peri 1 Yes eath (Check only Home 5 Res	tobacco use conformation (1988) an 24b. one) idence 6 Ott how injury occur	tribute to the cause of death 3 Probably 4 Unkr Were autopsy findings avaition of completion of causideath? 1 Yes 2 No ner (Specify)		
trending Physician: The law requires that the death certific death. stor: After this certificate has been signed by the attending prine tuneral director, page 2 should be detached for use as	rtification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a c. Due to (or as a d. 23c. If yes, outcome of the control of	f pregnancy Fetal death firme of death firme of death for the condition of	UE HEAM ant 3 DOA Oth A 28c. Injur Wor M 1	26. Place of De	24a. Was autopent 1 Yes eath (Check only Home 5 Res 28d. Describe	tobacco use conformation (1988) an 24b. one) idence 6 Ott how injury occur	onth Day Year tribute to the cause of deatl 3 Probably 4 Unkr Were autopsy findings avail prior to completion of causi death? 1 Yes 2 No		
trending Physician: The law requires that the death certific death. Stor: After this certificate has been signed by the attending prine tuneral director, page 2 should be detached for use as	rtification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a c. Due to (or as a d. 23c. If yes, outcome of the contribution of	f pregnancy Fetal death 3 Fetal death 5 Fetal death 5 Inot resulting in the CUNGESTI	underlying cause giv UE HEAM ant 3 DOA Oth of 28c. Injur Wor M 1 1 treet, factory, office	zen in Part I. FALLWUE 26. Place of December: 4 \(\text{Nursing} \) y at k? Yes 2 \(\text{No} \) me, date and place	24a. War auto perf 1 Yes eath (Check only Home 5 Res 28d. Describe 28f. Location City or To	Yes 2 No s an psy omed? 24b. one) idence 6 Oth how injury occur (Street and Numbur, State)	tribute to the cause of death 3 Probably 4 Unkr Were autopsy findings ava- prior to completion of causi death? 1 Yes 2 No ner (Specify) red ber or Rural Route Number, anner as stated.		
trending Physician: The law requires that the death certific death. stor: After this certificate has been signed by the attending prine tuneral director, page 2 should be detached for use as	rtification: To Be Completed by Physician/Medical	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a c. Due to (or as a d. 23c. If yes, outcome of the contribution of	f pregnancy Fetal death 3 Fetal death 5 Fetal death 5 Inot resulting in the CUNGESTI	underlying cause giv UE HEAM ant 3 DOA Oth of 28c. Injur Wor M 1 1 treet, factory, office	26. Place of Dener: 4 Nursing Yes 2 No	24a. War auto perf 1 Yes eath (Check only Home 5 Res 28d. Describe 28f. Location City or To	tobacco use cont Yes 2 No San Spsy ormed? 24b. one) idence 6 Oth how injury occur (Street and Numburn, State)	tribute to the cause of death 3 Probably 4 Unkr Were autopsy findings ava- prior to completion of causi death? 1 Yes 2 No ner (Specify) red ber or Rural Route Number, anner as stated.		
Attending Physician: The law requires that the death certific refeath. Attending Physician: The law requires that the death certificate has been signed by the attending pottor, page 2 should be detached for use as	rtification: To Be Completed by Physician/Medical	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a c. Due to (or as a d. 23c. If yes, outcome of the contribution of	f pregnancy Fetal death 3 Fetal death 5 Fetal death 5 Inot resulting in the CUNGESTI	underlying cause give HEAM ant 3 DOA Other ant 3 DOA Other ant 3 DOA of 1 DOA of 28c. Injury wor Wor 1 DOA treet, factory, office ath occurred at the time of the stigation, in my cause give and the stigation of the stiga	26. Place of Dener: 4 Nursing Yes 2 No	24a. War auto perf 1 Yes eath (Check only Home 5 Res 28d. Describe 28f. Location City or To	tobacco use cont Yes 2 No San Spsy ormed? 24b. one) idence 6 Oth how injury occur (Street and Numburn, State)	tribute to the cause of deatl 3 Probably 4 Unkr Were autopsy findings ava prior to completion of causi death? 1 Yes 2 No ner (Specify) red ber or Rural Route Number, anner as stated, and due to the cause(s) and (Month, Day, Year)		
trending Physician: The law requires that the death certific death. stor: After this certificate has been signed by the attending prine tuneral director, page 2 should be detached for use as	rtification: To Be Completed by Physician/Medical	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a c. Due to (or as a d. Due to (or as	f pregnancy Fetal death 3 Fetal death 5 For the state of death 5 Interest 2 ER/Outpatie Year 28b. Time Injury For the state of the state of death 10 Year 28b. Time 10 Year 28b.	underlying cause give HEAM ant 3 DOA Other of 28c. Injury M 1 Doal treet, factory, office atth occurred at the time to th	26. Place of Dener: 4 Nursing ry at rk? When the date and place opinion, death occurrence of the control of th	24a. War auto performed at the time	tobacco use configured to tobacco use configured tobacco use configured tobacco use configured tobacco use configured tobacco use configured tobacco use configured tobacco use configured tobacco use configured tobacco use (Street and Numble with State)	tribute to the cause of deatl 3 Probably 4 Unkr Were autopsy findings ava prior to completion of causi death? 1 Yes 2 No ner (Specify) red ber or Rural Route Number, anner as stated, and due to the cause(s) and (Month, Day, Year)		
tranding Physician: The law requires that the death certific death. stor: After this certificate has been signed by the attending prine tuneral director, page 2 should be detached for use as	rtification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a c. Due to (or as a d. Due to (or as	f pregnancy Fetal death 3 Fetal death 5 For the state of death 5 Interest 2 ER/Outpatie Year 28b. Time Injury For the state of the state of death 10 Year 28b. Time 10 Year 28b.	underlying cause give HEAM ant 3 DOA Other of 28c. Injury M 1 Doal treet, factory, office atth occurred at the time to th	26. Place of Dener: 4 Nursing ry at rk? When the date and place opinion, death occurrence of the control of th	24a. War auto performed at the time	tobacco use configured to tobacco use configured tobacco use configured tobacco use configured tobacco use configured tobacco use configured tobacco use configured tobacco use configured tobacco use configured tobacco use (Street and Numble with State)	tribute to the cause of deatl 3 Probably 4 Unkr Were autopsy findings ava prior to completion of causi death? 1 Yes 2 No ner (Specify) red ber or Rural Route Number, anner as stated, and due to the cause(s) and (Month, Day, Year)		

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Marylar		ertificate o			eg. No. 🤈 🛆 💍	· 1	
		1. Decedent's Name (First, Middle, Last) Physician /Medical MARY FOIT CARROLL						2. Dete of Dee Month May 26	th Day Ye	ear	ime of Deeth 2
-	Examir		4a. Facility Name (If not institution, give street and number) COLLEGE MANOR 5. Social Security Number 215-10-6630 6. Sex 1 M 2 F F Representation of the street and number of the street and nu				4b. City, Town, or Lutherv	n, or Location of Death 4c. County of Death			
1	Funeral Director						ear If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State			State or Foreign	
Baltimore, Maryland 21215-0020 permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If tem 27 is marked other then "naturel; or items 23e or 28e-f show any injury or other treumatic event, the Medical Eventher must be notified at once.	L	Usual Residence of Decedent 10a. State 10b. County								side City Limits	
	the Ma 28e-f s	recto	Maryland Baltimore County Lutherville 10e. Street and Number 10f. Zip Code				•		10g. Citizen of Whet Country?		
	23e or	ral Di	300 West Seminar			1093		USA			
	urs after des el', or items praminen	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puert No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Bleck, \ Specify:	American Inc White, etc. White	
	vithin 72 hor ne. hen "nature e Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	1	edent's Usual Oce e kind of work do DO NOT use ret omemaker	cupation ne during most of woi ired)	rking	16b. Kind of Busin		•
	filed v I Hygie other t	To Be Co	12th HO 17. Father's Name (First, Middle, Lest)			meniaker	18. Mother's Name (First, Middle, Maiden Surneme)			3	
	should be nd Menta marked		George F 19a. Informant's Name/Relationship (Type, Print)		oit Sad			ie Jacobs Rurel Route Number, City or Town, State, Zip Code)			·)
	permit. Pages 1 end Department of Health Important: if item 27 any injury or other t		Mr. J. Harvey Foi 20a. Method of Disposition 1 Strial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 21. Signature of Juneral Service License Martin D. Law	emoval from State	cemetery, cre ceen Mo 2	ount Cen	etery dress of Facility	5/27/2005	Baltimo	ore, Ma	aryland
	Physician /Medical Examiner	jr.	Martin D. Lawson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, approximatint interval Be conset and disease or condition resulting in death) Accident								
X & & Cou, satificate be executed ding physician and se es the buriel-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Diseese or injury that initiated events resulting in death) Last b									
y. DOX	deeth e etter ed for u	Physician/N	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.					23b. Did tobecco use contribute to the cause of deeth?			
ν. Ο.	es thet the deeth cert igned by the ettendin be detached for use	by Phy	AVENIA					1 ☐ Yes 2 127 No 3 ☐ Probably 4 ☐ Unk			4 🗌 Unknown
ecoras	The law requires that the death certain the law requires that the death certain the last been signed by the ettendire page 2 should be detached for use	Completed t						24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth?			prior to on of cause
VITA Ician: Sertifica rector,								1□Y		1 ☐ Yes	2 No
	tlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manuer of Death 1 Natural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Dey Yeer) 28b. Time of Injury Injury 28c. Ir				28d. Describe how injury occurred				
DIVISION	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this of completely filled in by the funeral directors.	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, off building, etc. (Specify)			ce	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Hospita 24 hours Funeral stely fille	Hospit 24 hour Funera etely fille	edical (29a. Certifier (Check only one) Check only one) Check only one) (Check only one)								euse(s)
,	To the compl	Me					29d. Date signed (Month, Day, Yeer) 216619 May 26, 2005				
1	11		30. Name and address of person who co	empleted cause of death (Ite	m 23e) (Type SFM/M	, Print)	E. LUTHE				
	Sta Regist		30. Name and address of person who con a contract of the contr	32. Registrar's Sign	ature	South	7				

State of Maryland / Department of Health and Mental Hygiene

						Cert	tificate of	Death	,	Reg. No. 2	05 15	1253
	Dhusisi		1. Decedent's Name (First, Middle, Las.))			·		2. Date of De Month	ath Day	3. Time	of Death
	Physici /Medio		Raymond H. Canto	er					May 19		9:35	PM
*	Examir		4a. Facility Name (If not institution, give					4b. City, Town, or	Location of Deat	h 4c. County	of Death	
			Manor Care Whea					Wheaton			gomery	
	Funeral		5. Social Security Number 6. Se	ox 7. Age ZM 2□F	(In yrs. last bir	rthday) _ Yrs.	If Under 1 Year Months Days		. (Month, Da		Birthplace (State Country)	or Foreign
	Director		579-24-0639		81	113.			Oct 27	, 1923	Washingto	n DC
	land		10a. State 10b. County		10c. City, Tow	n or Loca	ation				10d. Inside	City Limits
	Marylan -f show lled et	তৃ	MD Montgom	erv	Whe	aton					1 □ Y€	s 2√2 No
	r 28a	<u>ie</u>	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Country?	
	within 72 hours efter death with the Maryland ene. than 'natural', or items 23a or 28a-f show ha Madical Examinar must be notified at	Funeral Director	11901 Georgia Ave	nue				20902		U	JSA	
	deal	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U,S.	13. W	as Decedent of	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or No	- 14. Rac	ce - American Indian,	
2	e fe	F	1 Never Married 2 Married	1 AYes 2 No			□ Yes 2X No		, 0.0.,		v: White	
8	ural',	Q P	3 ☐ Widowed 4 ☐ Divorced	Year or Detes:	WWII							
<u> </u>	n 72 n	iete	15. Decedent's Edu (Specify only highest grad	ication fe co <i>mpleted)</i>	16a.	(Give ki	ent's Usual Occu ind of work done O NOT use retin	during most of we	orking unk	16b. Kind of B	usiness/Industry	
12	withi ene.	Completed by	Elementary/Secondary (0-12) unk unk	College (1-4or 5+ 1nk	+)	o. D	07707 000701	30)		phone	company	
D	filed Hygi sther ant, 1		17. Father's Name (First, Middle, Last)	IIIK				18. Mother's Na	me (First, Middle,	Maiden Suman	10)	
<u>a</u>	ld be ental kad c	To Be	James Reginald Ca	nter				Bertie	Foreacr	۵		
ary	shound M	_	19a. Informant's Name/Relationship (T	ype, Print)	195	. Mailing	Address (Stree	at and Number or F			State, Zip Code)	
Σ	alth a		Jeannette Hogan/n	iece	1	113	Harvard	Drive Da	avis, CA	95616		
Baltimore, Maryland 21215-0020	permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryla Department of Health and Mantal Hygiens. Paterment of Health and Mantal Hygiens "natural", or Items 23a or 28a-f show important: if Item 27 Is marked other than "natural", or Items 23a or 28a-f show important: if Item Madical Examinat must be notified at once.		20a. Method of Disposition	3	20b. Place o cemete	f Disposi ry, crema	ition (Name of atory or other pla	ace)	Date	20c. Location -	City or Town, State	
<u>Ĕ</u>	Pag nent int: II		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☒ Other (Specify,		2							
at	permit. Departr Imports any inju		21. Signature of Funeral Service Licens	999			Name and Addr	•	1 655 +>			
₾	89 5 8 9	10	xmuni	Nage, Did	CO.	Ba	ate Ana 1timore	tomy Boan MD 212	id 655 W. 201	Baltim	ore Stree	t
			26a. Part Enter the disease, or come shock or heart failure. List only of	lications that caused t	the death. Do					rrest,	Approxim Interval B	ate
1	Physician			-							Onset and	d Death
1	/Medical Examiner		Immediate Cause (Final disease or condition	a	Dn	ae-	none	1			1000	el
	Examine	-	resulting in death)		Due to (or as a	cons <i>e</i> qu	ence of):				-	
	ted nsit	Examiner	_	b			1					
	The law requires that the death certificate be executed attentions been signed by the ettending physician and page 2 should be deteched for use as the buriel-transit	Exar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		lue to (or as a	consequ	ence of).				İ	
68760,	sicial buri	edical	Cause (Disease or injury that initiated events	c	ue to (or as a	onegoue	ance of):					
89	ifficet g phy es th	중	resulting in death) Last	b	oue to (or as a t	Jonsoque	erice or).					
Вох	andin use	M/us		d							1	
ω.	thet the death cert ed by the ettendin deteched for use	Physician/	Part II. Other significant conditions co	ntributing to death but	t not resulting in	n the und	derlying cause g	iven in Part I.	23b. Did	tobacco usa co	ntribute to tha cause	e of death?
0	by the	Ph	CILE						1 🗆	Yaa 2 No	3 Probably 4	_ Unknown
'n.	w requires thet been signed b should be det								-		1	
Vital Records,	equir sen s nould	Completed by	domon tors						24a. Was perfo	an autopsy rm <i>e</i> d?	24b. Were autopsy available prior	r to
ပ္	e law r hes be ge 2 sh	Pie	1 :				A STATE OF S			0.	completion of of death?	cause
	The ete h	် ပ	alile						10	res ZONo	1 □ Yes 2	No
/ita	cian: entific actor,	Be	25. Was case referred to medical examiner?	I a a a la l				^	ath (Check only o			
of	hysi this c	ဥ	III les 1100	Hospital:			3 DOA		Home 5 ☐ Resid			
Ę	ling F	9	27. Manner of Death 1 Natural 5 Pending	28e. Date of Injury (Month, Day	Year) 280.	Time of njury		ork?]Yøs 2⊡No	280. Describe	now injury occur	<i>'e</i> d	
<u>S</u>	Attending Physician: or death. actor: After this certific by the funeral director,	licat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injur	rv - At home, fa	rm. stree			28f. Location (Street and Numb	er or Rural Route Nu	ımber.
	or A efter Dira	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	, 000	or, ractory, omico		City or Tox			
	spita nours neral y fille		29a. Certifier Certifying Phy	siclan: To the best of	my knowledge	, death o	occurred at the t	ime, date end plac	e, and due to the	cause(s) and ma	inner as stated.	
	To the Hospital or Attending Physician: The k within 24 hours effer death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only 2 Madical Exami	nar: On the basis of e and manner state	examination an	d/or inve	estigation, in my	opinion, death occ	urred at the time,	date and place,	and due to the cause	(s)
	Vith To th	Σ	29b. Signature and title of certifier		17.		29c. Licen	se number		29d. Date signe	d (Month, Day, Year)	
				-	m	0	DOC	X3578		May	35, 2001	Million.
			30. Name and address of person who co		ath (Item 23a)	Type, P	rint) 120	hace He	Olevi	,		
			31. Date filed (Month, Day, Year)	Ich Nerze		each	in, mo	20201				
	Sta	te	JUN 0 1 20	05 32 Registrar	s Signature	hon	All B					

DHMH 16 Rev 6/95

		ı	State of Maryland / Departr 1 - State Registrar Certifit	ment of Health and Micate of Death		ne 005	18254
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia /Medic		Vernon J. Disney		May 3	18, 2005	5:30 PM
	Examin	er	4a. Facility Name (If not institution, give street and number) Upper Chesapeake Medical Center	Bel Air	1	4c. County of Death Harfo:	rd
30 pm	Funeral		Mc Mc	Under 1 Year If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Birth	place (State or Foreign
0	Director		215-03-6074 1 M 2 F 88 Yrs. Mc		Sept. 1,	1916 Man	ryland
3	ow ow		10a. State 10b. County 10c. City, Town or Location	on			10d. Inside City Limits
5	ith the Marylar or 28e-f show	ector	Md. Harford	Fallston	140-		1 ☐ Yes 2 ☐ No
6	permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If time X7 is marked other than "netural; or Items 23e or 28e-f show any injury or other treumstic event, I'm Modical Examination injust to mailled at ORGE.	by Funeral Director	10e. Street and Number 2519 Hess Road	0f. Zip Code 21047	log	U.S.A.	nuy?
0	er dez	nue	Armed Forces?	Decedent of Hispanic Origin? (Sp s, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White,	
38/	ours after red', or I	1 by F	1 ☐ Never Married 2 ☐ Married 1 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes or Dates:	Yes 2√2 No Specify:		Specify: wh:	ite
5 50	72 h	Completed	(Specify only highest grade completed) (Give kind	s Usual Occupation of work done during most of work	king 16	b. Kind of Business/In	dustry
2 2 2	within ene. than	duo	Elementary/Secondary (0-12) College (1-4or 5+)	NOT use retired)		<i>c</i> .	•
20 2	Hygie Hygie other ent,	e Co	17. Father's Name (First, Middle, Last)	rial engineer 18. Mother's Nam	ne (First, Middle, Ma	lanufacturi iden Sumame)	ing
A fine	Mental Mental arked c	To Be	John Thomas Disney	Ella Ma	ay Higdon		
3845325/38 altimore, Maryland 21215-003	d 2 sho th and th sm treum			ddress <i>(Street</i> and Number or Rui Park Road, Bald			Code)
, e	theal		20a Method of Disposition 20b. Place of Disposition	n (Name of		c. Location - City or To	own, State
38453 Saltimore, Ma	Page:		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)	m. Gdns. 6/2/	′2005 F	allston, M	ſd.
Balti	permit Departi Importa any init		21. Signature of Funeral Service Licensee Sc	me and Address of Facility himunek Funeral	Home of	Bel Air, 1	inc.
5			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the				
	Name to form		shock, or heart failure. List only one cause on each line.	o mode of aying, out of ac our due	or roophatory arroot	,	Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death) a. Memoria				1 day
E	Examiner		Sequentially list conditions. b. Certbrovuscul	an Accide	'nt		5 days
SAS	rted	Examlner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
0,	be executed icien and burial-transil	Еха	that initiated events c. The sulting in death Last Due to (or as a consequence of):			-	-
7 M 2876(cate be physicie the bur	dical	d				
		0	IF FEMALE: 23c. If yes, outcome of pregnancy				
T X S	eath certif attending I for use as	clan	in the past 12 months?	opic pregnancy ner (specify)		23d. Date of deliver	ery Day Year
Z 0. 3	that the death	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown				
DO ds, P	es ign	1 by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underl	ying cause given in Part I.	23e. Did tobac	co use contribute to t	he cause of death?
ر ق	been s	etec			24a. Was an		psy findings available
$Ver_{\rm ital}$	ncien: The lav certificate has rector, page 2	Completed			autopsy performe	prior to co death?	mpletion of cause of
	en: I tificat tor, pa	e e	25. Was case referred to medical	26. Place of Dea	th (Check only one)	No 1 ☐ Yes	2 L No
~~ <u>`</u>		To B	examiner? 1 Yes 2 No Hospital: Supplied 2 ER/Outpatient 3	Other		e 6 Other (Specif	y)
- 7	After fune		27. Manner of Death 1. Natural 5 Pending (Month, Day Year) 28b. Time of Injury (Month, Day Year)	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
S n e	Attending r death. ector: Afte by the fune	fical	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street,		28f. Location (Stree	at and Number or Rura	al Route Number,
	rs after rel Dire	Certification:	a Dullding, etc. (Specify)		City or Town, S	·	
9	To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occ 2 Medical Exeminer: On the basis of examination and/or investigated.	urred at the time, date and place, gation, in my opinion, death occur	, and due to the caus rred at the time, date	se(s) and manner as s and place, and due to	tated. the cause(s)
-	withir To the	M	29b. Signature and title of certifier	29c. License number		Date signed (Month,	Day, Year)
	1		NI MIS	D3465	L M	ay 29,20	05
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print Scott Huswin 2 North	Avenus Bel	Air Mi	anyland	21014
Ē.	Sta Registr		31. Date filed (MDN), Pay Year) 2005 Place & Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) Year **Physician** 11:36PM MAY 30,2005 AMS 0 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Saint Joseph Medical Center If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** 1□M 219F 3 14 600 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a. State or 28e-f show treumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ⊞ No Director BRILAM 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Items 23a 21334 9803 VE Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 210 If Yes, Give Year or Dates: 1 Never Married 2 Married 21 No 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: 3 M Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) one MAKS 12762 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be HARRY B. An. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Importent: If item 27 Is eny injury or other tre once. 203 BALY LLC KANON Date 20c. Location - City or Town, Statè 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) TE Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 2002 BRYLAN ROSAS OF FAITH 22. Name and Address of Facility 21. Sun jure of Funer I Service Licensee 21234 a ENANZ CORPLYS 8800 HARFORD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between terval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DAYS CEREBROVASCULAR ACCIDENT /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?

1 Yes 2 No
9 Unknown ģ 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I Division of Vital Records, þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes ACUTE MYOCARDIAL INFARCTION Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy has 2 No certificate 1 ☐ Yes the Hospitel or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Inpatient 6 his 28c. Injury at Work? ate of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Dr ath After t Certification: (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined after 4 Homicide within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifiei Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 2 20 Ž D_37254

State Registrar

DHMH 17 Rev 1/2001

TOWSON MARYLAND 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day; Year)

76.21 OSI

	ı	1 - For Registrar	State of Ma	aryland /		rtment of H tificate of L				giene Reg. No.	2005	1825
		1. Decedent's Name (First, Middle, Las	st)					2	2. Date of De	ath Day	Year	3. Time of Death
Physic /Medi		Samuel Harry	DeCrispin	10					May	27	2005	8:50 AM
Exami		4a. Facility Name (If not institution, give Singi Hospital	A	more	,	4b. City, Town, or Baltin		of Death Ci Fo	4	4c. (County of Death	
Funeral Director		5. Social Security Number 6. S 213-05-2623	ex 7. Ago	90 (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	B. Date of Bir (Month, Da Dec. 1	th 1 <i>y, Year)</i> 0 , 191	Cour	
pua M		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation					11	10d. Inside City Limits
Aaryle f sho	ō	Maryland Baltim	ore	- 7,		nsville						1 ☐ Yes 2 No
the 288-	Director	10e. Street and Number	ore		oato	10f. Zip Code				10g. Citiz	zen of What Cour	ntry?
3a ou	o i	128 S. Symingto	n Avenue			2122	28		:	U	.S.A.	
death	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Ori	igin? (Spec	ify Yes or No)- 1	14. Race - Americ Black, White,	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumetic avant, the Medical Examinar must be notified at any or other traumetic avant.	by	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tyes 2 1 If Yes, Give Year or Dates:	WW II		Yes 2X No	Specify:		out, oto,		Specify: Whi	
72 ho	eted	15. Decedent's Ed (Specify only highest gra	ducation	11	(Give	ent's Usual Occupa	durina mos	t of working	g	16b. Kir	nd of Business/In	dustry
d within giene. rr than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		ness Owne	,			Pro	duce	
al Hyg	Be	17. Father's Name (First, Middle, Last,					18. Mothe	er's Name ((First, Middle	, Maiden	Sumame)	
Menta Menta arked	70	Harry DeCrispino							fonzo			
2 sho and is m		19a. Informant's Name/Relationship (1		g Address (Street a						
t and tealth im 27 thar t		Mary C. Miller 20a. Method of Disposition	(Sister)			assiter (sition (Name of	Circl	e Fin			ryland 2 cation - City or To	
ages or of B		1 🖾 Burial 2 ☐ Cremation 3 ☐		ceme	etery, cren	natory or other plac		6 6 6	2005			
nt Part		* 4 ☐ Donation 5 ☐ Other (Specifical Signature Fire all Service Lices		New		edral Cem		6-6-2				Maryland
Departition Depart		Make	Voll		16	Name and Addressitzke Fur	neral	Home	of Ca	tons	ville, I e. Marvl	nc. and 21228
		23a. Part1. Enter the disease, or com	plications that caused	the death. [e, mary	Approximate Interval Between
Pnysician	Į.	shock, or heart failure. List only Immediate Cause (Final disease or condition	. Pulma		O N	bolus						Onset and Death
/Medical		resulting in death)	a. Due to (or as			1000013		_				10 11007
Examiner		Sequentially list conditions,	Metas.	tatic	Me	rkel-cu	1 sk	in ca	ncer			3 yars
/ P #5	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequen	ce of):							,
and I-trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequen	ce of):		_	_			-	
icate be executed physician and sthe burial-transit	alE											
ficate physics the	edical		_ a.		-							
To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	ath 3	Ectopic pregnancy Other (specify)	1			2	23d. Date of delive Month	ery Day Year
d by t	Phy	9 Unknown Part II. Other significant conditions	contributing to death h	ut not recultin	g in the u	nderlying cause give	on in Part I		23e. Did	tobacco u	se contribute to t	he cause of death?
ires ti signe 3 be c	i by	Acute rena	. 0 11		ig iii tilo di	radity and oddado give	Cit iii r Cit i					bably 4 ⊟Unknown
y requ	etec								24a. Was	an	24h Were auto	opsy findings available
has ge 2	ompleted	Coronary he		(SC					auto	psy ormed?	prior to co death?	mpletion of cause of
in: The life at e or, pa	e Co	AOHIC STENC 25. Was case referred to medical	212				26 Place	e of Death	1 ☐ Yes (Check only	2 X No	1 Yes	2 No
ysicia ysicia s cert direct	0 8	examiner? 1 ☐ Yes 2√2 No	Hospital: 1 Inpatie	ent 2□ER	/Outpatien	t 3 DOA Oth					3 ☐Other (Specia	fy)
ding Phy h. After thi funeral o	tion: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	rv 28	b. Time of Injury	28c. Injun Wor		28	8d. Describe			
To the Hospital or Attanding Phys within 24 hours after death. To the Funaral Director: After this completely filled in by the funeral di	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At home c. (Specify)	, farm, str	eet, factory, office		28	8f. Location (City or To			al Route Number,
Hospita 24 hours Funaral	edical C		nysicien: To the best miner: On the basis o and manner st	f examination								
ro the round of the complex	Me	29b. Signature and title of certifier				29c. Licens					e signed (Month,	
. ,,,,		> Polf Kres	NE, M	0		RE.	2 - 0	000		May	27, 2	2.005
K		30. Name and address of person who ROLF P. KREM	completed cause of completed cause of completed cause of completed cause of complete cause of completed cause of	leath (Item 23	Ba) (Type,	Print)	of B	Ba1+1	more	2		
s	tate	31. Date filed (Month, Day, Year)		ar's Signature								
Regis	trar	96 921	0 1 2005	0		South	-					
DHMH 17 Rev 1	/2001	UUN	O I ZUUD ,	FRA	. PH.	Connex)	B					

ORIGINAL

			State of Maryland / Department	artment of Health and N	Mental Hygier	7110	18257
			1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	ay Year	3. Time of Death
	Physicia /Medic		Frances Elizabeth Dew		May 29	2005	1:45 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death	
			Manor Care 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Woodbridge Val	8 Date of Birth	Baltimor	e place (State or Foreign
	Funeral Director		213-09-6063 1 M 2 F 86 Yrs.	Months Days Hours Min.	Nov. 14,1	(r) Cou	1and
			Usual Residence of Decedent	<u></u>	1.0.1		
	anylan show	_	10a. State 10b. County 10c. City, Town or Lo				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Be-1:	Directo	Maryland Baltimore Catonsvil		100	Citizen of What Cou	
	with t a or 2 Libera	늅	10e. Street and Number 719 Maiden Choice Lane RGT334	10f. Zip Code 21228	109. (U.S.A.	
	heath	Funeral	· · · · · · · · · · · · · · · · · · ·	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri	can Indian,
٥	after or ther		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📆 No		Rican, etc.)	Black, White,	etc.
25	ours a	d by	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Wh:	ite
9500-612	filed within 72 hours after death with the Maryland Hygiene. Ither then "naturel", or items 23a or 28e-f show ent, the Medical Examination notified at	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of worl DO NOT use retired)	ting 16b.	Kind of Business/Ir	dustry
121	within ane. then	ф	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker		Own Hon	ne
N O	be filed tal Hygie d other svent,	e Co	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid		
<u>a</u>	be od o	To B	Frank Sweet	Annie S	tork		
Maryland	2 should be and Ment is marked eumatic s		19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Ru	al Route Number, City	y or Town, State, Zij	code)
	12 g			Winter Wind Court			
ore	of Head of Head If item		1 V Burial 2 Cremation 3 I Hemoval from State	matory or other place)		Location - City or T	own, State
Ĕ	. Pages Iment of Ient: If it jury or o		`4 □Donation 5 □Other (Specify) Loudon Pa	ark Cemetery 6-2-		timore, N	
Baltimore,	permit. Pages Department of I Importent: If its any njury or o once.		21. Signature of Service Lifensee M0/290 16	2. Name and Address of Facility Ltzke Funeral Home 530 Edmondson Ave.	of Catons Catonsvil	ville, In le, Mary	nc. and 21228
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or hear tailure. List only one cause on each line.				Approximate Interval Between
	Physician :	0.3	Immediate Cause (Final disease or condition	no ke			Swift
	/Medical Examiner		resulting in death) Due to (or as a consequence o):	n + f	1.		2000
	LAGITITICI	er	Sequentially list conditions, if any leading to immediate Due to (or as a consequent 0):	iew sclenstic	. orser	26	2905
	rted 	mlne	cause. Enter Underlying Cause (Disease or injury				
~	execun and ial-tra	Examin	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
8760	certificate be executed ding physician and use as the burial-transit	cal					
9	rtifical ng phy as th	0	IF FEMALE:				
30X	leath certific: attending pl	Physician/Me	23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3[Ectopic pregnancy		23d. Date of deliv Month	ery Day Year
O. B	D 0 0	sici	1 Yes 2 No 9 Unknown 9 Unknown	Other (specify)		World	July 1 5 m.
<u>.</u>	The law requires that the de ite has been signed by the a page 2 should be detached f		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
Records,	signe d be	d by	, and a second s	,	1 ☐ Yes	2 No 3 Pro	bably 4 Unknown
20	v require been si should I	Completed			24a. Was an	24b. Were aut	opsy findings available
He	The lay	ш			autopsy performed	? prior to co	ompletion of cause of
Vital		O	25. Was case referred to medical	26. Place of Dea	th (Check only one)	No 1 Yes	2 140
2	Physicien: this certificaral director, p	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	nt 3 DOA Other: 4 Wursing H	ome 5 Residence	6 ☐Other (Speci	fy)
0	ding Ph h. After th funeral		27. Mann of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 1 Natural 1 □ Pending	of 28c. Injury at Work?	28d. Describe how in	njury occurred	
<u>Ö</u>	endin sath. or: Af he fur	atic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division of	after death after death Director: /	ertification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or Rui ate)	al Route Number,
	pitel ours a erel C	O	29a. Certifier 12 Certifying Physicien: To the best of my knowledge, dea	th occurred at the time, date and place	and due to the cause	(s) and manner as	stated
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifies completely filled in by the funeral director.	edical	(Check only one) 2 Medicel Exeminer: On the basis of examination and/or in and manner stated.				
	To the within To the complex	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	Day, Year)
)	/		1 / Man What	ian D297	69	5/31	165
	6		30. Name and address of payson who completed cause of death (Item 23a) (Type	, Print)	2/1.2	1/2/	2/2/28
	9		Corcelis D. Alsverne c	ws 5 (M.	Golfmy K	d Buly	6 and
	Sta Registi		31. Date filed (Month, Day Year) 0 1 2005 Registrar's Signature	books			
	negisti	aı	December 10				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Denby May 29, 2005 Charles Joseph 12:01 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Name (If not institution, give street and number) Examiner Millennium Heath & Rehabilitation Center Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 🔀 M 2 🗆 F Yrs. Feb 27, 1958 Maryland Director 216-78-6358 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a Stete 10b. County 10c. City, Town or Location 7 is marked other than "naturel", or items 23a or 28e-f show traumatic event, the Medical Examiner must be notified at 1⊠ Yes 2 □ No MD Baltimore Completed by Funeral Director 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 5107 Pembridge Avenue 21215 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify. 3 Widowed 4 Divorced **Black** Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) al Hygiene. College (1-4or 5+) Elementery/Secondary (0-12) Security Balto. Washington Int. 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) permit. Pages 1 and 2 should be in Department of Health and Mental important: If Item 27 Is marked of Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Baltimore, MD 5107 Pembridge Avenue Elva Hebron Denby Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State ò 4 ☐ Donation 5 ☐ Other (Specify) May 31, 05 Hampstead, MD Carroll Cremation Ser 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 11824 Reisterstown Road Reisterstown, MD 21136 INTKHO Eline Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ac Examiner Due to (or as a consequence of) by Physician/Medical Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and bunal-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): for use as the 23b. Did tobacco use contribute to the cause of death? ate has been signed by the a page 2 should be detached Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed performed' 1□Yes 2MNo 1 ☐ Yes 2 ☐ No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Varsing Home 5 Residence 6 Other (Specify) 21 No Hospital: Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Menn of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 Yes 2 No 2 Accident the 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29 Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2005 Lucy 30. Name and address of person who completed cause of deeth, (Item 23a) (Type, Print) n/ . ·AHMED Eu Low 821

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Dey, Year)

32. Registrar's signature

sician	1 - State Registrer 1. Decedent's Name (First, Middle, Last)	С	ertificate of Death		ene J. No.	
ledical	Benedict	J.	Disimene	2. Date of Death Month MAY 3	Day Year	3. Time of Deal
aminer	4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death		4c. County of Death	
200	5. Social Security Number 6. Sex		av) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		MORE
eral ctor	214-26-7980 1X	7. Age (In yrs. last birthda M 2□F 7/ Yrs.	Months Dave Hours Min	April 16		place (State or For ntry) Arylan
4	10a. State 10b. County	10c. City, Town or	Location		1	10d. Inside City Lin
Funeral Director	MANYLAND BIZ/t	more Balti	More			1 ▼Yes 2 □
Dire	10e. Street and Number	TUENCE	10f. Zip Code 2 / 206	10g	D. Citizen of What Could	,
Funeral				pecify Yes or No-	14. Race - Americ	•
표	1 Never Married 2 Married	1 □ Yes 2 □ No	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	Rican, etc.)	Black, White,	
d by		If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: W	nite
Completed	15. Decedent's Educ (Specify only highest grade	completed) (Gi	cedent's Usual Occupation ive kind of work done during most of work	king 16	b. Kind of Business/In	dustry
료	Elementary/Secondary (0-12)	College (1-4or 5+)	5hoemaker		Shoe	Stop
ပိ	17. Father's Name (First, Middle, Last)		18. Mother's Nam	ne (First, Middle, Ma		
O	MARIO	Di Simo	one Ro	Se	127	TARO
-	19a. Informant's Name/Relationship (Typ	ne, Print) 19b. Ma	ailing Address (Street and Number or Ru			Code)
	DOMENICA BICKIL	C O / O	OI MARX AVENUE		MD 21	206
	20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Re	cemetery, c	rematory or other place)	_	c. Location - City or To	
	'4 □ Donation 5 □ Other (Specify)	Holy K	edeemer Cem Jun	e 4, 2005 t	1.4/41more	MARYL
ouce.	21. Signature of Funeral Service License	ė,	22. Name and Address of Facility HARTLEY MILLER 7527 HARFORD Re	2- 57EL	LA FRANKE	HOHEC
	23a. Part1. Enterthe Serve, or complic	ations that caused the death. Do not e	9527 Italiford Repeated the mode of dving, such as cardiac	or respiratory arrest	yore My z	Approximate
	23a. Part 1. En en le le le le, or complic shock, or le art le le List only one Immediate Cause (Phal			or roopilatory arroot		Interval Between Onset and Deat
n il	disease or condition resulting in death)	Due to (or as a consequence of):	NCER			
	Sequentially list conditions, b.					
ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):				
хаш	that initiated events c. resulting in death) Last	Due to (or as a consequence of):				
al Examine	resulting in death) Last	Due to (or as a consequence of):				
<u>a</u>	cause (Disease Chilipun) that initiated events resulting in death) Last d.	Due to (or as a consequence of):				
<u>a</u>	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregnancy	3∏Ectonic pregnancy		23d. Date of delive	*
<u>a</u>	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	c. If yes, outcome of pregnancy	3 □Ectopic pregnancy 5 □ Other (<i>specify</i>)		23d. Date of delive	*
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time ot death 9 Unknown	5 Other (specify)	23a Did toba	Month	Day Year
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions cont	Ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time ot death 9 Unknown	5 Other (specify)		Month	Day Year
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions cont	Ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time ot death 9 Unknown	5 Other (specify)	1 ☐ Yes	Month cco use contribute to the contribute to t	Day Year the cause of death pably 4 Munkn
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions cont	Ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time ot death 9 Unknown	5 Other (specify)	1 ☐ Yes 24a. Was an autopsy performe	Month cco use contribute to the contribute to the contribute to the contribute autoprior to condend to condend to condend to condend to condend to condend to condend to condend to condend to condend to condend to conde	Day Year the cause of death pably 4 Munkr psy findings avai mpletion of cause
e Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time ot death 9 Unknown	5 □ Other (specify)	1 Yes 24a. Was an autopsy performe 1 Yes 2	Month 200 use contribute to the contribute to the contribute to the contribute to the contribute to the contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to the contribute to contribut	Day Year the cause of death pably 4 Munkm the psy findings avai impletion of cause
o Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time ot death 9 Unknown	5 Other (specify) e underlying cause given in Part I. 26. Place of Deal	1 Yes 24a. Was an autopsy performe 1 Yes 2 K	Month cco use contribute to the contribute to the contribute to the contribute autoprior to condend to condend to condend to condend to condend to condend to condend to condend to condend to condend to condend to conde	Day Year the cause of death pably 4 Munkr psy findings avai mpletion of cause 2 \(\subseteq \text{No} \)
To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time ot death 9 Unknown Tributing to death but not resulting in the	26. Place of Deal ient 3 DOA Other: 4 Nursing Ho y 28c. Injury at Work?	1 Yes 24a. Was an autopsy performe 1 Yes 2 K	Month 2 No 3 Prob Profit o co death? No 1 Yes 24b. Were auto prior to co death? 1 Yes	Day Year the cause of death pably 4 Munkm psy findings avai mpletion of cause 2 \(\subseteq \text{No} \)
To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions context examiner? 1 Yes 2 No Ho 27. Manner of Death 1 Accident 1 Nestigation 3 Suicide 6 Could not be	Ic. If yes, outcome of pregnancy 1	26. Place of Deal ient 3 DOA Other: 4 Nursing Ho of 28c. Injury at Work? M 1 Yes 2 No	1 Yes 24a. Was an autopsy performe 1 Yes 2 th (Check only one) ome 5 Residence 28d. Describe how	Month 2 No 3 Prob 24b. Were auto prior to cord d? No 1 Yes 26 A Gother (Specifinjury occurred	Day Year the cause of death pably 4 Munkmings avail minimized of cause 2 No HOSPI
To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Ic. If yes, outcome of pregnancy 1	26. Place of Deal ient 3 DOA Other: 4 Nursing Ho of 28c. Injury at Work? M 1 Yes 2 No	1 Yes 24a. Was an autopsy performe 1 Yes 2 th (Check only one) ome 5 Residence 28d. Describe how	Month 2 No 3 Prob 24b. Were auto prior to co death? No 1 Yes 26 Sother (Specifi injury occurred	Day Year the cause of death pably 4 Munknot psy findings availa mpletion of cause 2 No H05 P1
Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Despital: Despital: Despi	26. Place of Deal 26. Place of Deal 27. Place of Deal 28. Injury at Work? M 1 Yes 2 No 28. Injury at Work? 1 Yes 2 No	24a. Was an autopsy performe 1 Yes 2 th (Check only one) ome 5 Residence 28d. Describe how 28f. Location (Street City or Town, Street at the time, date	Month 20 use contribute to the cool use contribute to the cool use contribute to the cool use t	Day Year the cause of death bably 4 Wunkn ppsy findings avail mpletion of cause 2 No No No No No No No No No No
To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Despital: Despital: Despi	26. Place of Deal 26. Place of Deal 27. Place of Deal 28. Injury at Work? M 1 Yes 2 No 28. Injury at Work? 1 Yes 2 No	24a. Was an autopsy performe 1 Yes 2 th (Check only one) ome 5 Residence 28d. Describe how 28f. Location (Street City or Town, Street at the time, date	Month 20 use contribute to the cool use contribute to the cool use contribute to the cool use t	Day Year the cause of death bably 4 Munkno ppsy findings avails impletion of cause 2 No No No No Route Number, tated. b the cause(s)
edical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Despital: Despital: Despi	26. Place of Deal 26. Place of Deal 27. Place of Deal 28. Injury at Work? M 1 Yes 2 No 28. Injury at Work? 1 Yes 2 No	24a. Was an autopsy performe 1 Yes 2 th (Check only one) ome 5 Residence 28d. Describe how 28f. Location (Street City or Town, Street at the time, date	Month 20 use contribute to the cool use contribute to the cool use contribute to the cool use t	Day Year the cause of death bably 4 Whitn posy findings avail mpletion of cause 2 No No No No Route Number, tated. b the cause(s)
edical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Despital: Despital: Despi	26. Place of Deal 26. Place of Deal 27. Place of Deal 28. Injury at Work? M 1 Yes 2 No 28. Injury at Work? 1 Yes 2 No	24a. Was an autopsy performe 1 Yes 2 th (Check only one) ome 5 Residence 28d. Describe how 28f. Location (Street City or Town, Street at the time, date	Month 20 use contribute to the cool use contribute to the cool use contribute to the cool use t	Day Year the cause of death bably 4 Munkm ppsy findings avai mpletion of cause 2 No No No No No No No No No No
edical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Despital: Despital: Despi	26. Place of Deat 26. Place of Deat ient 3 DOA Other: 4 Nursing Ho of Work? M 1 Yes 2 No street, factory, office 29c. License number	24a. Was an autopsy performe 1 Yes 2 th (Check only one) ome 5 Residence 28d. Describe how 28f. Location (Street City or Town, Street at the time, date	Month 20 use contribute to the cool use contribute to the cool use contribute to the cool use t	tated.

		1 - For State Registrar		State of M		•	tificate of			Reg. No.	2000	1826
hysici /Medic		1. Decedent's Name James		st) Dorsey					2. Date of De Month May 27	Day	/ Year	3. Time of Deat 1:24 A
/Medic Examin		4a. Facility Name (/		e street and number)			4b. City, Town, o	r Location of Dea			County of Death	1
		Stella Ma	ris Hospice	2			Baltimore				ltimore	
ıneral		5. Social Security N		CM 2DE	ge (In yrs. last		If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th y, Year)	Cot	place (State or For intry)
rector		214 36 870 Usual Residence of		X ^{M 2 F} 66)	Yrs.			May 12	1939_	Balt	imore,Maryl
Mo #		10a. State	10b. County		10c. City, T	own or Lo	cation					10d. Inside City Lie
유민	to	Maryland	Baltimore	2	Cockey	ysvill	e					1 ☐ Yes 2 ☐
r 28a	Irec	10e. Street and Nur	mber			·	10f. Zip Code			10g. Citi	zen of What Cou	ntry?
is marked other than "naturel", or Items 23a or 28a-f show eumatic event, the Medical Exemerationsi by notified at	Funeral Director	26 Silver 1	Fox Court				21030			USA		
ems	ıner	11. Marital Status		12. Was Decedent Armed Forces	Ever in U.S.	13. \	Was Decedent of H	lispanic Origin? (an, Mexican, Pue	Specify Yes or No erto Rican, etc.))-	14. Race - Amer Black, White	
P P	by Fu		ied 2 Married	1 ☐Wes 2 ☐ If Yes, Give	No		1 ☐ Yes 2 🛣 No	Specify:			Specify:	
urel'	q p	3 Widowed		Year or Dates:	1	6a Dococ	dent's Usual Docum	ation		16h Ki	Mni.	
"nai	lete		15. Decedent's E cify only highest gr	ade completed)		(Give	kind of work done DO NOT use retire	during most of w	orking	10D. KI	illa oi basiilessiil	ndostry
than the M	Completed	Elementary/Seco	ondary (0-12)	College (1-4or		Superv	isor	,		Soci	al Securi	ty Administ
s marked other the	Be C	17. Father's Name	(First, Middle, Last		1 -			18. Mother's Na	ame (First, Middle			
ked Ic ev	To B	James Edi	win Dorsev	Sr				Josephine	Luzzaro			
Importent: If item 27 is marked any injury or other treumatic ev once.	-	19a. Informant's N	ame/Relationship	Type, Print)		19b. Mailir	g Address (Street	and Number or f	Rural Route Numb	er, City o	r Town, State, Zi	ip Code)
27 ls er tre		Judith E	Dorsey (V	life)		26 S	ilver Fox	Court Co	ckcysville	, Mc	yland 210	30
item othe		20a. Method of Dis		Removal from State	0.000	e of Dispo etery, cren	sition (Name of natory or other pla	ce)	Date	20c. Lo	ocation - City or T	Town, State
ant: I			5 ☐ Other (Speci		Metro	o Crem	atory Inc l	May 31 200)5	Balt	imore, Mary	yland
y inju		21. Son after of Fu	uneral Service Lice	nsee	-	22	. Name and Addre	ss of Facility	Tre			
E 29 91		Meathy	2800	sho Chou	moki		401 Belair			vland	21236	
		23a. Part1. Enter t shock, or hea	the disease, or con art failure. List only	plications that cause one cause on each I	d the death. (ine.	Do not ent	er the mode of dyi	ng, such as cardi	ac or respiratory a	írrest.		Approximate Interval Betwee Onset and Deat
wician and burial-transit	I Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death)	5	c	a consequen							
attending physical for use as the t	by Physician/Medical	IF FEMALE: 23b. Was deceden	nt pregnant	d			Ectopic pregnanc				23d. Date of deliv	very
the atte	ysicia	in the past 12 1 ☐ Yes 2 I 9 ☐ Unknown	□No	4☐Pregnant a 9☐ Unknown			Other (specify)	, , , , , , , , , , , , , , , , , , , ,			Month	Day Year
signed by the a	Ph	Part II. Other signi	ficant conditions	contributing to death t	but not resultir	ng in the u	nderlying cause gr	en in Part I.	23e. Did	tobacco u	use contribute to	the cause of death
sign d be	d b								1 🗆	Yes 2	□No 3□Pro	bably 4 X Unkr
should t	Completed								24a. Was	an	24b. Were aut	topsy findings ava
2 5	E D								auto perf	psy ormed?	prior to c death?	ompletion of cause
certificate rector, pag		25. Was case refer	rred to medical					Of Place of D	1 ☐ Yes eath (Check only	2 No	1 L Yes	2 No
recto	o Be	examiner?		Hospital:	ient 2 TER	VOutpatier	nt 3 DOA Ott	100	Home 5 ☐ Res		6 X Other (Spec	ity) HOSPIC
ar this aral di		27. Manner of Dear		28a. Date of Ini	urv 28	Bb. Time of	28c. Inju	ry at	28d. Describe			"" HUSEIC
r; After e funer	atlo	1 XNatural 2 ☐ Accident	5 Pending investigation	(Month, Da	ay rear)	Injury	Wo M 1 □	rk? Yes 2 □ No				
I Director: d in by the	Certification;	3 Suicide 4 Homicide	6 Could not I determined	209. Flace of III	jury - At home tc. <i>(Specify)</i>	e, farm, str	eet, factory, office		28f. Location City or To			ral Route Number,
ФФ	edical C	29a. Certifier (Check only one)		hysician: To the best miner: On the basis and manner s	of examination							
Funer etely fill	(a)	29b. Signature and	title of certifier)			29c. Licen:	se number		29d. Da	te signed (Month	, Day, Year)
o the Funer ompletely fill	Σ		\				T				-10-	1
To the Funerel Director; After this certificate his completely filled in by the funeral director, page	2						()	4377	(5 127	105
To the Funer	2	•	Iress of person who	completed cause of	death (Item 2	3a) (Type	Print)	1372	5		5/27	105

			For State Registrar	State of Maryla	•	artment of F		lental Hygie	- 00000	10001
I	Physici /Medic		Decedent's Name (First, Middle, Last)	ROSE ANN	IE DO	NEGAN		2. Date of Death Month MAY 30	Day 2005 Year	3. Time of Death 2:40 A. M
	Examir		4a. Facility Name (If not institution, give s RENATSSANCE GARDEN		TOWN		r Location of Death NSVILLE		4c. County of Death BALT	
	Funeral Director			M 2/XF 7. Age (In yrs	s. last birthday, Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 04-29-19	9. Birth Cot 10 M/	place (State or Foreign Intry) ARYLAND
	aryland ahow		Usual Residence of Decedent 10a. State 10b. County		City, Town or L		-			10d. Inside City Limits 1 ☐ Yes ※ No
	th the M or 28a-f	Director	MD. BALTI 10e. Street and Number		انا	10f. Zip Code		10g.	. Citizen of What Cou	intry?
	ns 23a	Funerai D	1610 DIVISIO	2. Was Decedent Ever in	U.S. 13.	Was Decedent of H	21093 lispanic Origin? (Sp	ecify Yes or No-	U. S.	
920	ours after or rai', or Iter	by Fur	1 ☐ Never Married 2 ☐ Married XXC☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 XXVo	an, Mexican, Puerto Specify:	Rican, etc.)	Black, White	, etc. VHITE
21215-0036	be filed within 72 hours after death with the Maryland hat Hygiene. d other than "natural", or Items 23a or 28a-f ahow event, the Medical Examinar must be motified at	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 9 YEARS		(Give	dent's Usual Occup e kind of work done DO NOT use retired SECRET	during most of work d)	ing 16	EDUCATION	,
Maryland 2	0 = 0 \$	To Be Co	17. Father's Name (First, Middle, Last)	NRY VOELKE	R			e (First, Middle, Mai E SCHUB	,	
Mar	nd 2 sho alth and 1 27 is ma r traums		19a. Informant's Name/Relationship (Ty) M. EILEEN HOGAN (DAUGHTER)					ity or Town, State, Zi E,MARYLAN	
Baltimore,	Pages 1 a ent of Hec nt: If item ry or othe		20a. Method of Disposition 1 ☐ Burial ※※ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		cemetery, cre	osition (Name of matory or other place SERVICE CO	⁽⁹⁾		c. Location - City or TOWSON, MARY	own, State (LAND, 21204
Baltii	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic and one.		21. Signature of Funeral Service License		2	2. Name and Addre	ss of Facility	L HOME,ING	1050 Y C. TOWSON	ORK ROAD ,MD.21204
D	Pnysician		23a. Part 1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each line.		ter the mode of dyir				Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):					
1	uted ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events	Due to (or as a conse	equence of):					
8760,	death certificate be executed e attending physician and ind for use as the burial-transit	icai Exa	that initiated events resulting in death) Last	Due to (or as a conse	equence of):					
9	death certificat attending phy d for use as the	/Medi	IF FEMALE:	3c. If yes, outcome of preg	nancy				23d. Date of deliv	AND THE STATE OF T
.O. Box	that the death led by the atter detached for u	Physician/Med	23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
<u>α</u>	p p	by	Part II. Other significant conditions con	tributing to death but not re	esulting in the t	underlying cause giv	en in Part I.	23e. Did tobac	co use contribute to	
Records,	he law requir s has been si ge 2 should	Completed						24a. Was an autopsy performed	prior to co death?	opsy findings available ompletion of cause of
Vital	ysician: The is certificate hi director, page	Be Co	25. Was case referred to medical examiner?					1 Yes 2		20 No A 5 5 5 T E D
o	ding Ph .r After th funeral	tion; To	1 Yes 2 No Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 2[28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time of Injury	of 28c. Injur Wor	4 Nursing Ho	me 5 Residenc 28d. Describe how	-	WING-
Division		ertification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, si	reet, factory, office		28f. Location (Stree City or Town, S	t and Number or Rui State)	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edlcai C		icien: To the best of my kr er: On the basis of examinand manner stated.						
	To the within To the compl	Me	29b. Signature and title of certifier	11/		29c. Licens			Date signed (Month	
•	1		30. Name an address of person who co	mpleted cause of death (Ite	(em 23a) (Type	Print)	4/48	19	104 5/	ZOOS TENSULLE, MD
	1		MATTHEW V.	NAMMET	77	711 M	DIDEN (CNOICE	LANE, CA.	TONSUILLE, MD
	Sta Registi		31. Date filed (Mgntb Day) Year) 2005	A. Registrar's Sign	A CO	afe)				

			1- State of Maryland / Dep	oartment of Health and Me estificates of Peath		iene .s. N2 () () 5	18262
	Physici		Decedent's Name (First, Middle, Last) CATHERINE RUTH DIXON		2. Date of Death Month	Day Lo Zeer	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1,000	4c. County of Death	1. 1.1
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	OHO DUNL	R Date of Birth	Anne 14	rundel
	Funeral Director		212-46-1284 1 M 2 TF 61 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, JAN 17	Year) 1944	MD.
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or				10d. Inside City Limits
	Maryl I-f sho	tor		TIMORE			1 Yes 2 □ No
	or 28g	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	untry?
	eath w	Funeral	3814 HAGUE AVE. 11. Marital Status 12. Was Decedent Ever in U.S. 13	21225 Was Decedent of Hispanic Origin? (Spec		UNITED STA	
9	be filed within 72 hours after death with the Maryland stal Hygiene. do other than "naturel", or Items 23a or 28a-f show event, the Medical Examinational to notified at		1 ☐ Never Married 2 Married I ☐ Yes 2 M No II Yes, Give M	 Was Decedent of Hispanic Origin? (Speinf Yes, specify Cuban, Mexican, Puerto F Yes 2 No Specify: 	Rican, etc.)	Black, White	, etc.
-0036	hours lurel',	ed by	3 Wildowed 4 Divorced Year or Dates:			Specify: WH	
<u>)</u>	- 2	Completed	(Specify only highest grade completed) (Given	edent's Usual Occupation re kind of work done during most of workin . DO NOT use retired)	ng		,
27.	filed within Hygiene. Ither than "	Com	8 F	IOMEMAKER		OWN HOME	
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Ma	To Be	17. Father's Name (First, Middle, Last) LEMMUEL HARDY	18. Mother's Name MARTHA		STEWART	
ary	s 1 and 2 should be f Health and Mental item 27 is marked o other traumatic eve	F	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street and Number or Rural	l Route Number,	City or Town, State, Z	ip Code)
	os 1 and 2 of Health a litem 27 is rother trai			O3 POTOMAC ROAD, EDG	_		21037
nor	80 = 5		1 Tiburiai 21 Cremation 31 Hemoval from State 1	position (Name of Peratory or other place) IEMORIAL PARK 5/31/		Oc. Location - City or TUMBERLAND,	
Baltimore,	그 든 만 는						
Ä	Depar Impor eny ir			22. Name and Address of Facility CHA 6224 EASTERN AVE.,			ND 21224
H			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final		r respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Reval + all to Due to (or as a consequence of):	(Ve			
	Examiner		Sequentially list conditions, b. Sepsis				
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
o,	cate be executed oblysician and the burial-transit		that initiated events c Due to (or as a consequence of):				
8760	icate be physici s the bu	dicai	d				
ox 6	eath certific attending pl	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deli	very
Ω.	The law requires that the death certificate be executed to has been signed by the attending physician and ite has been signed by the attending physician and ite burial-transit	Physician/Medical	in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{Yes} \) 0 \(\text{Velocity of death} \) 5	Ctopic pregnancy Control of the cont		Month	Day Year
P.0	that the de ed by the detached		9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
rds,	w requires tha been signed should be de	ed by			1 □ Ye	s 2□No 3□Pro	bably 4 Dunknown
Records,	e law re has bee je 2 sho	Completed			24a. Was an	prior to c	topsy findings available ompletion of
al R	(D) TT					No 1 □ Yes	2 13 No
Vital	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	ent 3 DOA Other: 4 Nursing Hom		nce 6 □Other (Spec	ufy)
n of	ding Ph h. After th funeral	on; T	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time (Month, Day Year)	of 28c. Injury at 2 Work?		w injury occurred	
Division	Mtsndi death ctor: A	ficati	2 Accident investigation 3 Suicide 6 Could not be 28e, Place of Injury - At home, farm,	M 1 ☐ Yes 2 ☐ No	28f. Location (Str	eet and Number or Ru	ral Route Number.
Div	tel or / s after el Dire ed in b	Certification;	4 Homicide determined building, etc. (Specify)		City or Town,	, State)	
	To the Hospitei or Attanding within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edicai (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Exeminer: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, a investigation, in my opinion, death occurre	and due to the ca ad at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
	To the within 2	Mec	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month	Day, Year)
	~		Deorge C. Write III	1U. 141365	1	lay 26, 0	2005
	10		30. Name and address of person who completed cause of death (Item 83a) (Typ	1D. D41365 O. Print) Hospital Driv	ie, Glen	Burnie, t	10, 21061
	Sta		31. Date filed (Mpp) Pay Year) 2005		/		
	Regist	rar	JOH () I 2003 Flow It for	va			

amend item#17, 19a-b, per Inf. G844, 6/20/05 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Erns)ohn 01 05 /Medical 4b. City, Town, or Location.

BATI MURL

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (Sie Country) |
April 9, 1929 | Mary Land 4a. Facility Name (If not institution, give street and number) Examiner MARY LAW MEDICALATOR UNIVESIM 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1₩ 2□ F 219-22-0216 Yrs Director 76 Usual Residence of Decedent the Marylend 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits ?? is marked other than "natural, or iteme 23a or 28e-f show treumatic event, Ite Madical Examinar must be multilad at 1 ☐ Yes 2 ☐ No Marvland Berlin Worcester Co. Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 10 Harbormist Cr. 21811 United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Xi Yes 2 □ No If Yes, Give Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after d Department of Heelth and Mental Hygiane. Importent: if item 27 is marked other than "natural", or item any injury or other treumatic event, the Mudical Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ð Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Procurement Director Comcast Telesystems 12 years vears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Ernest Mary Hohn ¹⁹1 **Callin Hares Street at Structure Front Page Number City of The Page 11** Harbormist Cr. Berlin, MD 21811 19a. Informant's Name/Relationship (Type, Print) Nancy D. Ernest (wife) Berlin, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State Báyview Crematory 6-1-2005 Baltimore, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McCully—Polyniak Funeral Home,
130 E. Fort Ave. Baltimore, MD 21. Signature of Funeral Fervice Licensee 21230 Wayne Osterling Part : Solar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ardias disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate causa. Entar Unioning Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificete hes been signed by the attending physicien and rector, page 2 should be detached for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of); Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month 4☐ Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ESOPHAGEAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death, 2 Accident investigation Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours after To the Funerel Dire Hoapitel 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) ů, 29b. Signature and title of pertified 29c. License number 29d. Date signed (Month, Day, Year) 132528 MD 761 5×1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greave Street BACTIMUNE 22 GAMLIEL 32. Regis ar's Signature 31. Date filed (Month, Day, Year) State PARIAN Registrar

		For State Registrar		ryland / Dep <i>Ce</i>	artment of I rtificate of			jiene leg. No? () ()	5 18261
Physici /Medic			ne1berger				2. Date of Dea Month May	21 200 S	
Examir	ner	4a. Facility Name (If not institution, give : Moran Manor Nurs				or Location of Deat ernport	h	4c. County of	Death Legany
Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday,	If Under 1 Year	If Under 24 Hrs	8. Date of Birth		Birthplace (State or Foreign Country)
Director		Usual Residence of Decedent	M 2 X F	79 Yrs.	Months Days	Hours Min.	(Month, Day Aug. 14	,1925	West Virginia
arylar show	_	10a. State 10b. County		10c. City, Town or L					10d. Inside City Limits
the M.	Funeral Director	WV Minera 10e. Street and Number	L	Keyse	10f. Zip Code			log. Citizen of Wha	1X Yes 2 No
3e or	2	500 Carskadon	Lane Ant	101	267	726		USA	
death	nera		12. Was Decedent E- Armed Forces?			Hispanic Origin? (S pan, Mexican, Puer	pecify Yes or No-		American Indian,
ed within 72 hours after death with the Maryland gigne. er than "natural", or Itams 23e or 28e-f show . The Madical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 💥 Widowed 4 ☐ Divorced	1 [] Yes 2 XX No If Yes, Give Year or Dates:		1 ⊡ Yes 2 XX No		o rican, ecc.)	Specify:	White, etc. White
.⊆ _ ⊒	Completed	15. Decedent's Edu (Specify onfy highest grade	cation e completed) College (1-4or 5+	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of wo	rking	16b. Kind of Busin	ness/Industry
filed with Hygiene. ther than	Com	8			Homemaker	c		Owi	n Home
nd 2 should be file Ith and Mental Hy 27 Is marked oth traumatic evant	Be	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
d 2 should be th and Menta 7 Is marked traumatic ev	၉	Glen Myers 19a. Informant's Name/Relationship (Ty	na Print)	10b Maili	na Addrona (Stran	BLa t and Number or Ri	nche Kuy		ata Zin Co da)
nd 2 sho aith and 27 is m r traum		Mary E. Parrish/			General I		New Cre		26743
He He		20a. Method of Disposition		20b. Place of Dispo			Date	20c. Location - Cit	
Pages nent of int: If Its		1 X Burial 2 ☐ Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Bethel C	•	May 20		Old Fiel	lde WV
permit. Pag Department Important: I any injury o	1	21. Signature of Euneral Service Licens	ee /		2. Name and Addre			eral Home	
Dep Imp		10 man	. Duell	<u> </u>	85 S.	Main Str			26726
Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line	cons quence of):		ing, such as cardia	c or respiratory an	est,	Approximate Interval Between Onset and Death
ate be executed hysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):					
at the death certific by the attending p tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes No	3c. If yes, outcome o 1□Live birth 2 4□Pregnant at ti 9□ Unknown	Fetal death 3	⊒Ectopic pregnanc ⊒ Other (specify) _	y		23d. Date o Month	*
The law requires that the law requires somether the last been signed by the age 2 should be detache	b	Part II. Other significant conditions con	ntributing to death but	not resulting in the u	nderlying cause gr	ven in Part I.			ute to the cause of death? ☐ Probably 4 ☐ ☐ Tkmowr
w require been si should b	lete	Went Fr	- Lule	7.000			24a. Was a	in 24h Wei	re autopsy findings available
	Completed						autop	sy prio med? dea	r to completion of cause of
Physician: this certific	o Be	25. Was case referred to medical examiner?	lospital:		Ot	G Co	ath (Check only or		
ling After fune		1 Yes 2 X No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	t 2 ☐ ER/Outpatien 28b. Time of Year) Injury	f 28c. Inju	4 Truirsing F		ence 6 Other ((Specify)
Attan deat ctor: y the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, st (Specify)			28f. Location (S City or Tow	treet and Number (n, State)	or Rural Route Number,
To the Hospitel or / within 24 hours after To the Funaral Dira completely filled in b	Medical C	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Exemi	sician: To the best of ner: On the basis of e and manner state	examination and/or in	h occurred at the ti vestigation, in my	ime, date and place opinion, death occu	, and due to the corred at the time, co	ause(s) and manno ate and place, and	er as stated. If due to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licen	se number	2	9d. Date signed (A	Month, Day, Year)
		100	\sim		D	21244	7	5/25	105
6		30. Name and address of person who co	.D. Frost	tburg Plaz	Print)		21532	,	
	ite	31. Date filed (Month, Day, Year) JUN 0 1 200		's Signature	uli)	0, -3			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Eckloff MAY 005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** N/A Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. February 27, 1946 5. Social Security Number Birthplace (State or Foreign Country)
 MD. 6. Sex 1**X** M 2□ F 7. Age (In yrs. last birthday) **Funeral** 216-44-0187 59 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Edgewood 1 ☐ Yes 2 X No MD Harford Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1423 Harford Square Drive 21040 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ₺ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or lien any injury or other trainment. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Drywall Finisher 8 years Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Millard Eckloff Laura Baer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1423 Harford Square Drive, Edgewood, MD. 21040 Mary Eckloff wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 31. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BAyview Crematory 2005 Baltimore City, MD. 21. Signature of Funeral Service Licenses ^{22. Name and Address of Facility} Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk,MD. 21222 23a. Part1. Enter the dise set or complications that caused the d_ath_ Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. Dist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Massive Myocardial 2 DAYS /Medical Due to (or as a consequence of) Examiner 20 YEARS Arter Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 2 No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 27. Manner of Death 1 Natural 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 🛮 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) To the 29c. License number 29d, Date signed (Month, Day, Year) AT 243 8946- ES MAY 28 2005 M.D. 30. Name an address of per se who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

GAUTAM

31. Date filed (Month,

MEMORIAL HOSPITAL BALTIMORE NO

VNION

Glown It footes

22. Registrar's Signature

M.O.

GULATI

(Month, Day, Year) JUN 0 1 2005

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

			1 - For Registrar	State of Marylan		artment of I		, ,	iene	05 10-
	Physici /Medic		1. Decedent's Name (First, Middle, Last	in Ever	-lihe	<u></u>		2. Date of Deat		- UT AU
	Examir Funeral Director	ner	5. Social Security Number 6. Se	od Orive		4b. City, Town, of the lift Under 1 Year Months Days	or Location of Death A 5 2 10 10 10 10 10 10 10 10 10 10 10 10 10		4c. County of De War (1924 Ma	
	9	or	Usual Residence of Decedent 10a. State 10b. County MD Washing	10c. Cit	y, Town or Lo	cation		11		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the P 23a or 28e-	Funeral Director	10e. Street and Number 114 Greenwood Dri		mage	10f. Zip Code	740	10	g. Citizen of What	21
920	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28e-f show he Madical Examinar must be notified at	ρ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Vas Decedent of H f Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ar Black, WI Specify: W	
21215-0036	d within 72 ho giene. or than "natu the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 1 2		(Give	lent's Usual Occup kind of work done DO NOT use retire homemak	during most of work d)	sing	6b. Kind of Busines	ŕ
Maryland	should be filed ind Mental Hygis s marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Harry Irvin Engli 19a. Informant's Name/Relationship (Ty		10b Mailin	a Address (Street	Emma Pa	e (First, Middle, Muline Sm	ith	75-0-4)
Baltimore, Ma	Pages 1 end 2 nent of Health a int: if itam 27 is iry or other tra		Hugh Everline/spo 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Serve Licens	USE 20b. F	114 (Place of Dispo- emetery, cren	Greewood sition (Name of natory or other pla	Drive Ha	erstown,	City or Town, State MD 2174 Oc. Location - City of	40
Ba	permit. Depertring imports any inju			dade, Differen		<u>Saltimore</u>	tomy Boar	201	Baltimon	ce Street Approximate
8760,	Cate be executed physician end physician end physician end the buriel-transit	dical Examiner	Immediate ouse (Final disease or o adition resulting in death)	ne cause on each line.	uence of):	i.	rnsion			Interval Between Onset and Death
P.O. Box 6	he deeth certifi the attending I thed for use es	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	,		23d. Date of d Month	elivery Day Year
ords, P.	w requires that the bear signed by should be detact	by	Part II. Other significant conditions con	Myclosensu	į.	derlying cause giv	en in Part I.	23e. Did toba		to the cause of death? Probably 4 □Unknown
tal Rec		e Completed	25. Was case referred to medical	Nellits			26 Place of Death	24a. Was an autopsy perform 1 Yes 2	ed death / ⊇No 1 □ Ye	autopsy findings available completion of cause of
Division of Vital Records,	Physic this ce	Certification; To B	27. Manneyof Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At ho	ER/Outpatient 28b. Time of Injury	28c. Injur Wor M 1 🗆	er: 4 □ Nursing Ho y at k? Yes 2 □ No	me 5 Resider 28d. Describe how	nce 6 Other (Sp v injury occurred	ecify) Rural Route Number.
Δ	To the Hospitel or Attending within 24 hours efter death. To the Funerel Director: After completely filled in by the fune		29a. Certifier 1 Certifying Phys	building, etc. (Specify	v)	occurred at the tir	ne, date and place.	City or Town,	State)	as stated
	To the Hospitei within 24 hours e To the Funerei if completely filled	Medical	29b. Signature and title of certifier	ner: On the basis of examinal and manner stated.	lion and/or inv	29c. Licens	e number		d. Date signed (Mor	nth, Day, Year)
			30. Name and address of person who co		23a) (Type, F		(. 66 D	11	5.24.	
2-	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 1 2005	32. Registrar's Signal		enical.	CUMIUS	Nage	NOWN	IVIU

			1 - For State Registrar	State of Maryla	and / Depa <i>Cei</i>	artment of He rtificate of D	ealth and Mo Death		ene () ()	5 18267
	Physici	an	Decedent's Name (First, Middle, La THORA ILENE FAUS	•				2. Date of Death Month	Day	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, gir	re street and number)		4b. City, Town, or L		MA	4c. County of	Death
			Saint Joseph 5. Social Security Number 6.		rs. last birthday)	If Under 1 Year	TOWSO	8. Date of Birth		altimore
	Funeral Director			1□M 2XPF 85	Yrs.	Months Days	Hours Min.	June 22,	1919 j	9. Birthplace (State or Foreign Country) Plymouth, Iowa
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	e Man	ctor	Maryland Baltimo	re		Baltim	nore Coun	ty		1 ∐ Yes 2 √ ∏(No
	with th	Directo	10e. Street and Number 202 Sipple Avenu	Р		10f. Zip Code	21236	10	g. Citizen of Wh	nat Country?
	ems 23	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. \	Was Decedent of Hisp f Yes, specify Cuban,		cify Yes or No-	14. Race	- American Indian, White, etc.
36	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or items 23a or 28a-f show event. The Medical Exercians crust be invitted at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2000No If Yes, Give Year or Dates:	1	1 ☐ Yes 200X No	Specify:	iloan, etc.)		White
215-0036	72 hou	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Deced	dent's Usual Occupati kind of work done du DO NOT use retired)	ion pring most of working	1	6b. Kind of Busi	ness/industry
121	within lene. than *	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		JSewife			lousekee	ping-Own Home
Maryland 21	al Hygie d other avant.	Be C	12 yrs. 17. Father's Name (First, Middle, Las.	2 yrs.			18. Mother's Name	(First, Middle, M	aiden Sumame)	
Z	hould to Ment marked marked	10	Frank Lane 19a. Informant's Name/Relationship	Type Print)	10h Mailia	ng Address (Street an		ne Thomp		7-0-4
	and 2 s alth an 127 is a		Frank L. Faust (2 Pembrook				
ore	ges 1 and of He		20a. Method of Disposition XIX Burial 2 ☐ Cremation 3 ☐		. Place of Dispo cemetery, cren	sition (Name of natory or other place)	5-31-	2005		ity or Town, State
Baitimore,	permit. Pages 1 and 2 should be fil Department of Health and Mental H Important: If item 27 is marked oft any injury or other traumatic evan once.		4 □ Donation 5 □ Other (Special Symbols Idea)	1 11		Cemetery Name and Address	-4.5		Baltimo	
ñ	Dep Imp		Multo	aff	Ц.	7401 Belai	r Rd. Ba	sahn Fur ltimore.	Md. 21	
			33a Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	plications that caused the de one cause on each line.	eath. Do not ente	er the mode of dying,	such as cardiac or	respiratory arres	st,	Approximate Interval Between Onset and Death
	Prrysician /Medical		disease or condition resulting in death)	a CEREBROV Due to (or as a cons		R ACCIDE	NT			
	Examiner	<u></u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	ngueros of					
Ţ	uted id ansit	Examiner	cause. Enter Uniderlying Cause (Disease or injury that initiated events	C C C C C C C C C C C C C C C C C C C	equence or).					-1
ე	ificate be executed physician and ss the burial-transit	ıi Exa	resulting in death) Last	Due to (or as a conse	equence of):					
68/60,		edicai		_ d						
žon	that the death certified by the attending detached for use a	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnancy			23d. Date of	
	the dea y the a tched f	hysicia	1 ☐ Yes 2 Ø No 9 ☐ Unknowh	4□Pregnant at time of 9□Unknown	fdeath 5□	Other (specify)			Month	n Day Year
ς, Σ	requires that the een signed by th nould be detache	by PI	Part II. Other significant conditions			nderlying cause given	in Part I.	23e. Did toba	acco use contribu	ute to the cause of death?
cord		eted	STATUS POST CORO	NARY ARTERY B	SYPASS			1 Tes		Probably 4 Unknown
Ď	hysician: The law his certificate has b I director, page 2 sl	ompieted						24a. Was an autopsy performe	ed? pric	re autopsy findings available or to completion of cause of ath? Yes 24 No
	Physician: 'this certifica	BeC	25. Was case referred to medical examiner?	No.			26. Place of Death			Yes 2/1 No
	Physi or this c oral din	T. To	1 ☐ Yes 2 No 27. Manner of Death	28a. Pate of Injury	ER/Outpatient	28c. Injury a	t 28	e 5 🗌 Residen		(Specify)
UNISION	ending sath. or: Afte he fune	ation	1 Natural 5 Pending investigatio		Injury	Work?	s 2 No		,,	
Š	I or Att after de Diract	ertification;	3 ☐ Suicide 6 ☐ Could not be determined		home, farm, stre cify)	eet, factory, office	28	Bf. Location (Stre City or Town,		or Rural Route Number,
	To the Hospital or Attending Physwithin 24 hours after death. To the Funaral Director: After this completely filled in by the funeral director	0	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	nysician: To the best of my ki	nowledge, death	occurred at the time,	, date and place, ar	nd due to the cau	ise(s) and mann	er as stated.
	thin 24 thin 24 the F omplete	Medicai	one) 29b. Signature and rifle of lettler	niner: On the basis of examinand manner stated.	nation and/or inv	29c. License n				Month, Day, Year)
	F * F 8		- Coult	truin. 1)	ì		Ø 34	3	5/27/	05
	10		30. Name and address of person who	completed dause of death (Ite	em 23a) (Type, F		en lair I		1-11	
74"	Sta	e	31. Date filed (Month, Day, Year)	D 7611 05	LER DR		ON MARY	LAND 2	1204	
	Registr		JUN U I	2005 32. Figistrar's Sign	natura,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death

Physician /Medical Examiner

Funeral Director

the Maryland item 27 is marked other then "netural", or items 23e or 28a-1 show other traumatic event, the Medical Examinar must be notified at be filed within 72 hours after death al Hygiene. Mental is marked 1 and 2 should Department of Health Importent: If item 27

Physician /Medical Examiner

ŏ

injury (

any ir

Pages 1

Hospital or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit P.O. Box 68760, for signed t Division of Vital Records, page 2 should director this After after death. Director: A

Examine Physician/Medicai þ Completed Be Certification: To filled in by within 24 hours a To the Funeral E Medicai completely

For State Registrar 1. Decedent's Name (First, Middle, Last) Helen M. Fellows lacility Name (If not institution, give street and number) 4c. County of Death City, Town, or Location of Death Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Age (In yrs. last birthday Months Days Hours Min. 1 ☐ M 2 🛣 F 214-28-5762 71 01/13/1934 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Tyes 2X No Gerrardstown WV Berkley Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 25420 1248 Nancy Jack Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ☐ Yes 2 🛣 No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Specify. 3 ₩idowed 4 Divorced It Yes, Give Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Domestic 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bessie Jane Marshall John Elmer Wilcox SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1248 Nancyjack Road Gerrardstown WV. 25420 Michael W. Fellows 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/26/05 Martinsburg WV. 25401 Rosedale Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 21. Signature of Funeral Service Licensee 6415 Belair Road Baltimore, Maryland 21206 23a. Part1. Enter the disease, or complications that consed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on see line. Approximate Interval Between Onset and Death Immediate Cause (Final Verce disease or condition resulting in death) Due to (or as a consequence of): troke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): *IF FEMALE* ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 1 ☐ Yes 2 ☑ No 1 Inpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 🗌 Yes 2 No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of fnitury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 1/2001

State

Registrar

5

30. Name and address of person

31. Date filed (Month, Day, Year)

JUN 0

1 2005

the

23a) (Type, Print)

tho completed cause of death (Item

UG

DI

32 Registrar's Signature

		1 - For State Registrer	State of Marylan		rtment of H			ene g. No.	
		1. Decedent's Name (First, Middle, Las	')				2. Date of Death Month	Day Year	3. Time of Death
Physic /Medi		HOWARD JE	ROME	FLEAC	JLE		MAY	27, 2005	12:30 P.M
Exami		4a. Facility Name (If not institution, give GENESIS ELDERCARE	street and number) PERRING PARKW	YAY	4b. City, Town, or PARK\	/ILLE		4c. County of Death BALTIM	
Funeral Director		212-03-3500	7. Age (<i>ln yr</i> s.	last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1/15/19	Year) Cou	place (State or Foreign ntry) (LAND
pur		Usual Residence of Decedent 10a, State 10b, County	10c. Cit	y, Town or Loc	ation				10d. Inside City Limits
Maryla	tor	MD BALTIM	ORE	PARKVII	LLE				1 ☐ Yes 2 🛣 No
or 28s	Funeral Director	10e. Street and Number	DOAD		10f. Zip Code 21234	<u>'</u>	10	g. Citizen of What Cou USA	intry?
sath v	era la	8333 HILLENDALE	12. Was Decedent Ever in U	.s. 13. W	as Decedent of H	ispanic Origin? (S	pecify Yes or No-	14. Race - Amer	
within 72 hours after death with the Maryland liene. liene. r than "netural", or Itams 23a or 28a-1 show the Medical Examinations the modified at	by Fune	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates: WWII	lf	Yes, specify Cuba ☐ Yes 2K No	Specify:	o Rican, etc.)	Black, White	, etc. WHITE
2 hours		15. Decedent's Ed	ucation	16a. Deced	ent's Usual Occup	ation	at day and	6b. Kind of Business/I	
within 72 lene. than "not the Medi	Completed	(Specify only highest gra	College (1-4or 5+)	life. D	O NOT use retired	()		BALTIMORE (BOARD OF E	
illed within the street than the street than sant, the street than sant, the street than sant, the street the street than sant, the street the street than sant, the street than sant, the street than street the street than street the street than street the street than street that street than street than street than street than street than st		9TH GRADE 17. Father's Name (First, Middle, Last)		L TEP	D INSPEC		me (First, Middle, M		300.
ed tal	To Be	HOWARD L. FLEAGL		T		PAULI	NE MCGINN	IS	in Code)
C, INC. y	1 8	19a. Informant's Name/Relationship (ISABELLE FLEAGLE/			g Address <i>(Street</i> HTLLENDA		BALTIMOR	City or Town, State, Z.E., MD 212	
		20a. Method of Disposition	20h I	Place of Disnor	sition (Name of			20c. Location - City or 1	
		1 Durial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specif	Removal from State JES		TH. CH.			COCKEYSVIL	
parmit. Pages 1 a Department of Hes Importent: If itsm any injury or othe		21. Signature of Funeral Service Licer	- Huje	101	Name and Addre			N FUNERAL I	HOME, P.A. 1286
Pnysiciar /Medica Examine	e e	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. Due to (or as a consect b. Due to (or as a consect b.		my	mia			Onset and Death
The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai Examin	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consec	quence of):					
that the death certificated by the attending produced for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9☐ Unknown	aldeath 3⊑	Ectopic pregnanc Other (specify)	у		23d. Date of deli Month	Day Year
ires that signed b		Part II. Other significent conditions of Anemuca		sulting in the u	nderlying cause gr	ven in Part I.	23e. Did tob	pacco use contribute to es 2 MPNo 3 □ Pro	the cause of death? obably 4 □Unknown
HECOLOS, he law requires t e has been signe age 2 should be	etec	Anemia Conquestir	- Heart	Fa	ilure	>	24a. Was a	n 24b. Were au	topsy findings available completion of cause of
VICAL FREC sician: The law s certificate has b lirector, page 2 s	Completed by						autops perform	ned? / death?	2 No
- 10	(I)	25. Was case referred to medical				26. Place of De	eath Check on on	8	
OT VITA Physician: this certific ral director,	To B	examiner? 1 Tyes 2 100		ER/Outpatier	T 3LIDOA		7	ence 6 Other (Spec	cify)
E gc ge	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time o Injury	Wa	ry at rk?]Yes 2 □ No		ow injury occurred	
DIVISION If or Attanding after death. Director: Atted in by the fune	ertific	3 Suicide 6 Could not to determine determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str ify)	eet, factory, office		28f. Location (St City or Town	treet and Number or Ru n, State)	ıral Route Number,
DIVISIO To the Hospital or Attandit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier 1 Certifying P (Check only one) 2 Medicel Exe	nysician: To the best of my kr miner: On the basis of examir and manner stated.	nowledge, deat nation and/or in	h occurred at the t vestigation, in my	ime, date and plac opinion, death occ	ce, and due to the courred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
To tha within: To tha comple	Med	29b. Signature and title of certifier				se number	_	9d. Date signed (Mont	_
		1 Might	Cis, m	ı	Doe	5985	·	May 2	12005
3+1		30. Name and address of person who	completed cause of death (Ite	om 23a) (Type, 560/	Print) Lock	Rave	en Blu	d Bal	timore
5	State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	1				

DHMH 17 Rev 1/2001

-atto, Dorla Box 68760.

Physician

/Medical

Examiner

	Please Type or	Print in Black Ind	lelible Ink. Ensure A	II Copies	s Are Legible.	
_ For	State o	f Maryland / Depa	rtment of Health and I	Mental Hy	/giene	
- State Registrar		Cen	tificate of Death		Reg. No. 200	5 100
1. Decedent's Name	(First, Middle, Last)			2. Date of D		3. Time of De
Dorla	Geneva Gat	to		May	31 200	5 8:55
4a Facility Name (If	not institution, give street and nu	mber)	4b. City, Town, or Location of Death	, 0	4c. County of Dea	ath
Frankli	n Square Ho	spital Center	Rosedale		Balt	imore
Social Security N	umber 6. Sex	7 Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bi	rth 9. Bi	rthplace (State or Fi
214-20-61	69 1 M 245 F	84 Yrs.	World Days Hours Will.	June 2		ryland
Usual Residence of	Decedent					
10a. State	10b. County	10c. City, Town or Loc	ation			10d. Inside City L
Maryland	Baltimore	Middle Ri	ver			1 🗆 Yes 2
10e. Street and Nun	nber		10f. Zip Code		10g. Cîtizen of What C	ountry?
28 Longer	on Drive		21220		II C A	

Tankli Social Security Nu **Funeral** oreign Director 214-20-61 Usual Residence of death with the Maryland 10a. State imits 7 is marked other then "neturel", or items 23a or 28a-f show treumatic event, the Medical Examinat must be rediffed at ZNo Director Maryland 10e. Street and Nun 28 Longer Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status ☐ Yes 2 📆 No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify Specify: by 3 XWidowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0·12) College (1-4or 5+) 10 Lineworker Phone Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Welch Loudermilk Millie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is m eny injury or other treum once. Jason Richard Moorhouse (Grandson) 28 Longeron Drive Middle River, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Memorial Gard. Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Essex, Maryland 21221 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Fnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Be Completed by Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1010nal 1 ☐ Yes 2 **1**00 Hospitel or Attending Physicien: 25. Was case referred to examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 😱 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) r of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 24 hours a pellij 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) HO060576 completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

likowski

Franklin Square Drive Baltimore, MD 21251

		•	1 - For State Registrar	State of Ma	ıryland		artment of				giene Rea. No	711114	1827	
			Decedent's Name (First, Middle, Last	st)						2. Date of De	ath		3. Time of Death	-
	Physicia		Stanley Glaser							Month May	28, Day	2005 Yeer	2315 M	
7	/Medic Examin		4e. Facility Name (If not institution, give	street and number)			4b. City, Town,	or Location	of Death		4c	. County of Deeth		
lt.			Collingswood Nurs	ing Home			Rockvi					ntgomery		
E Comment	Funeral Director		103-03-8749	ex 7. Age	(In yrs. li	ast birthday) Yrs.	If Under 1 Yea Months Day		24 Hrs. Min.	8. Date of Bir (Month, De Dec 28	th y, Yeer)	9. Birthp Cour 17 New	olece (Stete or Foreign ntry) York	7
	and w	}	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits	_
	Mary	ō	Maryland Montgome	2017	C - 1	er Spr	inc						1 ☐ Yes 2 X No	
	r 28a	Director	10e. Street and Number	Ly	SIIV	er obi	10f. Zip Code				10g. Cit	izen of What Cou	ntry?	_
	th with	aiD	9611 Cottrell Ter	race			20903				USA			
	ems (Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	er in U.	S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Or ban, Mexica	igin? (Spec	cify Yes or No lican, etc.))-	14. Race - Ameni Black, White,		
36	within 72 hours after death with the Maryland ene. Than "natural", or Itams 23a or 28a-f ehow he Medical Excrete must be notified at	by Fu	1 Never Married 2 Marned	1 X Yes 2 □ N If Yes, Give	lo		1 □ Yes 2 🎇 N					Specify:		
Ö	hours tural	d b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:W	MTT	16a Dece	dent's Usual Occ	upation			16b K	Whit ind of Business/In		_
7	in 72	jete	(Specify only highest gra	de completed)		(Give	kind of work don DO NOT use reti	e during mos	st of workin	g	100.10	and of businessin	dustry	
212	iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	Stati	stician				Pub1	lic Healt	h Service	
Maryland 21215-0036	a filed Il Hygie other	BeC	17. Father's Name (First, Middle, Last)					18. Moth	er's Name	(First, Middle	Maiden	Sumame)		
ılar	vid be Mental irked c	ToE	Irving Glaser					Anna	Bell	e Glas	er			
lan	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship (**			•				-	or Town, State, Zip	Code)	
	and ealth m 27		Laura Billetdeaux	/daughter	OOL D		Herman	Road		ester,			- Chan	
ore	Pages 1 nent of H int: If itel iry or oth		20a. Method of Disposition 1 Burial 2 X Cremation 3	Removal from State	200. P	ace of Dispo emetery, crei	sition (Name of matory or other p	lace)	June		20c. L	ocation - City or To	own, State	
Baltimore,	permit. Pag Department Important: I any injury o	1 %	*4 □Donation 5 □Other (Specif				1 Crema		200			nton, Mar		_
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Insportant: If item 27 is marked other than "natural", or itams 23a or 28a-1 show any privator other traumatic event, the Medical Express. Institute at once.	(i - 5)	21. Signature of Funeral Service Licer	anth	МО	1251Be	ing Homeverly L	e Crem Heck	ation	Servi P.A.	ce C1a	P.O. Box	784 , MD 21029	9
760,	Physician /Medical Examiner per price prigrature in price prince price p	ical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter thospharing Cause (Disease or injury that initiated events resulting in death) Last	cone cause on each lin a. Metastat Due to (or as a complete or a com	ic S a consequa	quamou uence of): uence of):							Interval Between Onset and Death	
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physicien and bagge 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	□Ectopic pregnar □ Other (specify)					23d. Date of deliv	ery Day Year	
<u>a</u>	w requires that been signed b should be deta	by	Part If. Other significant conditions of	contributing to death bu	ut not resu	ulting in the u	nderlying cause (given in Part	l.	23e. Did 1			he cause of death?	1
Vital Records,	v requ	Completed								24a. Was		1	opsy findings available	_
Rec	has ge 2	m								auto	psy ormed?	prior to co death?	empletion of cause of	
a		CC	25. Was case referred to medical					26 Plac	e of Death	(Check only		1 Yes	2 No	_
	Physician: The I rthis certificate ha ral director, page	To B	examiner? 1 ☐ Yes 2 📉 No	Hospital: 1 ☐ fnpatie	nt 2 🗆	ER/Outpatie	nt 3 DOA					6 ☐Other (Special	fy)	
Division of	Attending Physic death. •ctor: After this by the funeral di		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injui (Month, Day	ry	28b. Time of Injury	f 28c. In		2	8d. Describe				
Divis	i the	Certification:	3 Suicide 6 Could not be determined	e 28e. Pface of Injubulding, etc			reet, factory, offic	ee	2	8f. Location (City or To		nd Number or Run e)	al Route Number,	
	Hospital 24 hours a Funeral (etely filled	Medical C	29a. Certifier 12 Certifying Pt (Check only 2 Medical Examone)	nysician: To the best on miner: On the basis of and manner sta	of my kno examina ated.	wledge, deat tion and/or in	h occurred at the vestigation, in m	time, date a y opinion, de	nd place, a ath occurre	nd due to the	cause(s date an) and manner as s d place, and due t	stated. to the cause(s)	
	within 2 To the Comple	Me	29b. Signature and title of centiler	1			29c. Lice	nse number			29d. Da	ite signed (Month,	Dey, Year)	_
	1		/ Ellan	In		- W	20	412	12		5	/3//09	5	
1	DT/	7	30. Name and address of person who Charles Harrison					ad Roc	kvill	e, MD	2085	55		_
Ĭ	Sta		31. Date filed (Month, Day, Year)	32 Registra	ar's Signa	ture			***	-				_
	Regist	ell	2 4	DA Patet	2 K	5	27.							

DHMH 17 Rev 1/2001

			For State			nd / Depa		t of H	ealth a		Mental Hyg		005	18272
			Registrar 1. Decedent's Name (First, Middle, La	st)					-		2. Date of Deat	 h		3. Time of Death
	Physici		George William Go	schen							May Month	26 ^{ay}	2005	11:45 AM
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and nun	nber)		4b. City,	Town, or	Location of	of Death		4c. Co	unty of Death	
	LX		5723 Oakland Road	1			A	rbut	us				Balti	more
	Funeral		5. Social Security Number 6. S		7. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth	Year)	9. Birth	nplace (State or Foreign
	Director		220-24-4813	[XM 2□F	77	Yrs.		,-			Sep. 7,	1927	Ma	irýland
	and **		Usual Residence of Decedent 10a. State 10b. County		10c. C	ty, Town or Lo	cation							10d. Inside City Limits
	Manyli f sho	ō	MD Balt:	imore				Arbu	tue					1 □ Yes 2 No
	the ?	rect	10e. Street and Number	LIIIOLE			10f. Zip		Lus		1	0g. Citizen	of What Co	untry?
	3a or	by Funerai Director	5723 Oakland Road	1					21227	,		Uni	ted St	ates
	death ms 2	ner	11. Marital Status	12. Was Dece Armed For	0007	J.S. 13. V	Vas Deced	lent of H	spanic Ori	gin? (Sp	pecify Yes or No- Rican, etc.)		Race - Ame	
9	after or ite	/Fu	1 ☐ Never Married 2 X Married	1 XYes	2□No 10	-30-45	Yes 2	_	Specify:		Triloan, etc.)	+	Black, White ecify: Wh	ite
8	ours ural', IExe	d b)	3 Widowed 4 Divorced	Year or Da	ites: 12-4	-46								
7	"nati	Completed	15. Decedent's E (Specify only highest gra	ducation ide completed)		16a. Deced	lent's Usua kind of wor DO NOT us	il Occupa k done d	ation during mos	t of work	king	16b. Kind o	of Business/I	ndustry
7	withir ene. than	duc	Elementary/Secondary (0-12)	College (1	-4or 5+)				, loyed			Ins	urance	e e
Maryland 21215-0036	filed Hygi othar	e Cc	17. Father's Name (First, Middle, Last,)		1		Ì	-		e (First, Middle, M	Maiden Sur	mame)	
an	lid be ental kad c	To Be	Frank J. Goschen						An	na N	4. Bucher	r		
ary	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If itam 27 is merked other then "natural", or items 23s or 28s-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	g Address	(Street a	and Numbe	er or Rur	al Route Number	City or To	wn, State, Z	ip Code)
Σ	and 2 alth a 127 is		Marlyn Goschen	Vife		5723	0akla	and	Road,	Art	outus, M	212	27	
ore.	es 1 e of He of He roth		20a. Method of Disposition 1 Burial 2 Cremation 3	Domoval from S	State	Place of Dispo	natory or o	ther plac					on - City or	
Ĕ	Pages nent of I ant: If its ury or o		Donation 5 Other (Special		Ba						-31-2005			
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or othar ance.		21. Signature of Funeral Service Lice	1200	700						rose Fur			
_	20 E # 9	1	annume!	MA							g Rd., A1		s, MD	
Ę.			Se Part Enter the disease, or com shock, or heart failure. List only	plications that ca one cause on ea	aused the dea ach line.	th. Do not ent	er the mod	e of dyin	g, such as	cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. M=	TASTA	TIC C	02.61	00	ANG	ER				44115
П	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):								. /
	Harry Co.	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	quence of):								
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	_										
oʻ	exec an an		resulting in death) Last	Due to (or as a conse	quence of):								
1760,	ite be iysicië ne bu	cai		_ d										
68 2	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE:											
Вох	ath ce	ian/	23b. Was decedent pregnant in the past 12 months?		rth 2 Fet	aldeath 3□	Ectopic pr					23d.	Date of deli	very Day Year
P.O.	w requires that the death been signed by the atte should be detached for	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregni 9☐ Unkno	ant at time of	oeath 5∟	Other (sp.	өспу)						
	that t ed by detar	/ Ph	Part II. Other significant conditions	contributing to de	ath but not re	sulting in the u	nderlying ca	ause give	en in Part I		23e. Did tob	acco use	contribute to	the cause of death?
g.	uires I sign Id be										1 □ Y€	s 2 N	o 3□Pro	obably 4 Unknown
COL	w req	Completed									24a. Was a	n 2	4b. Were au	topsy findings available
Re	he la e has age 2	mc		PA - A - A4A-							autops	y ped?	prior to d death?	ompletion of cause of
tal	an: T tificat or, pa		25. Was case referred to medical				_		26 Place	of Deat	1 ☐ Yes 2 th (Check only on	No No	1 L Yes	2 No
>	ysicia s cert direct	To Be	examiner? 1 Tes No	Hospital:	npatient 2	ER/Outpatien	t 3 DO	A Oth	0.0	rsing Ho			Other (Spec	cify)
101	g Ph		27. Manner of Deam	28a. Date o		28b. Time of	_	8c. Injun	at		28d. Describe ho			,,
<u>ö</u>	offendin death. ctor: Afr y the fur	atio	1 Natural 5 ☐ Pending investigation	n	,	nijoty	М		Yes 2	No				
Division of Vital Records,	l or Atte after de Diracto I in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	208. Flace	of Injury - At h	nome, farm, str	eet, factory	, office			28f. Location (St. City or Town	reet and N n, State)	umber or Ru	ral Route Number,
	oitel o urs aff rai Di							_						
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Diractor: After this certificate has completely filled in by the funeral director, page 2	Medicai	29a. Certifier (Check only one) Certifying PI Certifying PI Certifying PI	niner: On the ba	isis of examin	owledge, death ation and/or inv	occurred restigation,	at the tin , in my o	ne, date an pinion, dea	id place, ith occ <i>u</i> r	and due to the ca red at the time, da	ause(s) and ate and pla	d manner as ice, and due	stated. to the cause(s)
	o the ithin 2 o the	Mec	29b. Signature and title of certifier	and manr	iei stateu.		290	. License	number		2:	9d. Date si	gned (Month	ı, Day, Year)
}	6 → ≰ →		+ Kouls A	umbe	, M.	1		DI	828	37	1	MAY	7.7	7005
	(,)	-	30. Name and address of person who	completed can's	e of death (Ite	m 23a) Дуре,	Print)	1		-	0	174/	21	
	1		PAUL GORM	44	900	CAT	ON	AV	E	1	SALTIM	1 ARIZ	MO	21229
	Sta		31. Date filed (Month, Day, Year)		egistrar's Sign	ature		, -						*
	Registr	ar	JUN	0 1 200	El ma	se de	1	RAN.	,					
DH	IMH 17 Rev 1/2	001			e de la constante de la consta	ORIGINA	1	No.						
						UNIGHYA	-							

		_	For State Registrar	State of M	aryland		artment of I rtificate of		1	R	eg. No U	15	82	73
	Physicia		1. Decedent's Name (First, Middle, La William Edward G	ossman						2. Date of Deat May 22,		Year	3. Time of De 2253	ath M
	/Medic Examin		4a. Facility Name (If not institution, git 2205 Byton Court		1		4b. City, Town, o				4c. County o	ford		
	Funeral Director		5. Social Security Number 6.	Sex 7. A	ge (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days		Min	3. Date of Birth (Month, Day Aug • 27	Year) 1933	9. Birthp Court Mar	lace (State or F	oreign
	yland how		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	ecation					1	0d. Inside City I	
	h the Ma r 28a-f s	Director	Md. Hari	ord			Fore	st Hi	.11	1	0g. Citizen of W	hat Cour	1 Tes 2	X NO
	th with	aiD	2205 Byton Court				210	50			U.S.	Α.		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-f show amy injury or other treumatic event, the Madreal Examiner must be natified at ODGe.	Completed by Funeral	11. Marital Status 1 □ Never Married 2 □ ★Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 Yes 21X If Yes, Give Year or Dates:	?	ł	Was Decedent of If Yes, specify Cub 1 ☐ Yes 2X No			ify Yes or No- ican, etc.)		k, White,	an Indian, etc. ite	
21215-0036	thin 72 ho e. an "natur Modical I	npieted	15. Decedent's E (Specify only highest gi		5+)	16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation during moded)	st of working	g	16b. Kind of Bu			
2	iled wi tygien ther th nt, the	Con	12 years 17. Father's Name (First, Middle, Las	<i>t</i>)			manageme		ner's Name	(First Middle II	State o		ryland	
Maryland	Mental H arked of atic ever	To Be	Frank Gossman					Ger	neviev	e Stead	lman			
Mar	is 1 and 2 sho of Health and item 27 is m other treum		19a. Informant's Name/Relationship Shirley Gossman				Byton C							
nore,	ages 1 a ant of He it: If item y or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		сел	netery, crei	sition (Name of matory or other pla Mem. Gdr		5/26/		20c. Location - (Be1 Ai			
Baltimore,	permit. F Departme Importan any injur		21. Signature of Funeral Service Lice		- 202	_	Name and Address Schimune	ess of Facil	iera1	Home of	Bel Ai	ir, I	inc.	
	Pnysician /Medical Examiner	ner	23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury)	a U	line. S a contique	Caro	610 W. Mer the mode of dy	ing, such as	s cardiac or	respiratory arre	AII , F	(Approximate Interval Batwer Onset and Dea	en ath
x 68760,	death certificate be executed e attending physician and od for use as the burial-transit	Physician/Medical Examiner	that initiated events resulting in death) Last	c. Due to (or a: d. 23c. If yes, outcom	s a conseque						23d. Date	a of dollars		_
P.O. Box	that the death cer ed by the attendir detached for use	hysician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 4 Pregnant : 9 Unknown	2 Fetal d	eath 3[Ectopic pregnand Other (specify)	у			Mor		Day Yea	ır
	ires sign d be	by	Part II. Other significant conditions	contributing to death	but not result	ing in the u	nderlying cause gr	ven in Part	. I.		oacco use contri es 2□No	ibute to th		
Vital Records,	The ate h page	Completed								24a. Was a autops perform	ned? p	Vere auto rior to cor eath? Yes	psy findings ava mpletion of caus 2 No	ulable se of
	Physician: Th rthis certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpat	iont 20E	R/Outpatier	nt 3□ DOA Ot	hon	e of Death	(Check only on	e) ence 6 ⊡Othe	r /Sagaih	u)	
on of	ding Phys h. After this funeral di	H 1	27. Manner of Death 13. Natural 5 Pending 2 Accident investigate	28a. Date of Inj (Month, D	ury 2	8b. Time o Injury	f 28c. Inju		28		ow injury occurre		//	
Division	I or Attending after death. Director: After I in by the fune	Certification;	3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of Ir	njury - At hom etc. (Specify)	ie, farm, st	reet, factory, office		28	Bf. Location (St City or Town	reet and Numbe n, State)	er or Rura	l Route Numbe	r,
1	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C		hysician: To the bes miner: On the basis and manner s	of examination									
33	To th within To th comp	Me	29b. Signature and title of certifier	100			29c. Licen	se number			9d. Date signed			
Ğ	4:		30. Name and address of person	authorities of cause of) death (Item 2	23a) (Type.	Print)	5546		1	lay 25,	20	5	
	Y		Dr Charles Pad	act 56	01 400	-hR	aven B	we,	Ball	TIMOTO	M	212	39	
	Sta Registi		31. Date filed (Month, Pay Year)	30 Regis	trar's Signatu	re Ace	ales				•			

		1- For State of Maryland / Department of Health and Mental Hygiene Certificate of Death	18274
		Decedent's Name (First, Middle, Last) 2. Date of Death	3. Time of Death
Phys /Me	ıcıan dical	Anna Cantuari	5 6:10 PM
Exan	niner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE MD 4c. County of D	eath
Funer Directo			Birthplace (State or Foreign Country) ennsylvania
P ≥		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
death with the Maryland ms 23e or 28e-f show	Director		1 ☐ Yes 2 ☑ No
with th	al Dire	10e. Street and Number 10f. Zip Code 10g. Citizen of What 707 Maiden Choice Lane #3104 21228 USA	Country?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene Important: I flem 27 Is marked other than "natural", or Itams 23e or 28e-1 ehov any injury or other traumstic event, the Nedical Exuminant technolified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. His Positive Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
bre, Maryland 21215-0036 ss 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene it fam 27 is marked other than "natural", or ita	leted t	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	ss/Industry
212- ed withir ygjene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 1 Homemaker Own Home	2
and S ba fill ad oth	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
arylishouk shouk and Me	2	Jame Frain Margaret Kennedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State	e, Zip Code)
Mc and 2 and 2 and 2 is ar trau		Thomas Gentner Son 6053 Ivy League Drive; Catonsville, MD	21228
Baltimore, permit. Pages 1 ar Department of the montant: If the montant: If the montant: If the montant in the montant or other		20a. Method of Disposition 1	
Baltii Sermit. F Separtmi mportar any injur	ouce	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sterling Ashton Schwab Funeral Hop	ne,Inc.
		736 Edmondson Avenue; Catonsville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	Approximate
Physicia /Medica		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CEREBROVASCULAR ACCIDENT	Interval Between Onset and Death
Examine	er	Due to (or as a consequence of): Sequentially list conditions, Tany leading to immediate Due to (or as a consequence of):	
n and ial-transit	Examiner	Tany leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	
	Ical	d.	
NE M. P.O. Box 68760 that the death certificate be ed by the attending physicial detached for use as the bur	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	delivery Day Year
	b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	to the cause of death? Probably 4 Unknown
w requ	Completed	24a. Was an 24b. Were	autopsy findings available to completion of cause of
of Vita Physician: this certificatial director,	To Be	examiner? 1 Yes 2 No	pecify)
Fing S 7			
GENTINER Division of Vita To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Diractor: After this certific completely filled in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or City or Town, State)	Rural Route Number,
Diversity of the Hospital or in 24 hours after the Funaral Diversity filled in It appliedly filled in It.	edical C		as stated. due to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo	
Į,		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. W. COLE MO STAGNES 900 CATON AVE BALT. MD 31. Data tilled (Month Pay Year) 32. Registrar's Signature	5,2005
	Statė	E.W. COLE MD STAGNES 900 CATON AVE BALT, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature	21229
Regi			
DHMH 17 Rev	1/2001	JUN 0 1 2005 Blave B. Species	

			1 - For State Registrar	State of Mai		partmen <i>ertificat</i>				F	leg. No.	05	1827	15	
	Physici	an	Decedent's Name (First, Middle, Last,							2. Date of Dea Month	Day	Yeer	3. Time of De	atn M	
	/Media		Anna Theresa 4a. Facility Name (If not institution, give			4h City	Town or	Location of	of Dooth	May		2005 Ity of Death	8:50P		
	Examin	ıer							or Death						
-	Funeral		Carroll Hospital 5. Social Security Number 6. Secu		(In yrs. last birtho	(ay) If Under	1 Year	ster If Under		8. Qate of Birth	1	1 rro 11 9. Birth	place (State or Fo	oreign	
	Director		219-14-1329]M 2 X]F	93 Yrs	Months	Days	Hours	Min.	Jan. 11	, Year) , 1912	Cou	ntry) MD		
	P .		Usual Residence of Decedent												
	arylar show	<u>_</u>	10a. State 10b. County		10c. City, Town o								10d. Inside City L 1 ☐ Yes 2		
	8a-f	Director	MD Carrol	1	Finks		-							<u>J</u> 140	
	with t	늅	10e. Street and Number			10f. Zip					10g. Citizen o		ntry?		
	eath	Funerai	2929 Club House	Road 12. Was Decedent Ev	er in U.S.		2104		gin? (Sp	ecify Yes or No-		ISA ace - Ameri	can Indian.		
_	fter d r Iten	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🖸 No						ecify Yes or No- Rican, etc.)	В	ack, White	etc.		
3	ol', o	þ	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2X No	Specify:			Spec	ity: Wh	ite		
5	72 ho	Completed	15. Decedent's Edu (Specify only highest grad		16a. D	ecedent's Usua	I Occupa	ation	t of work	ina	16b. Kind of	Business/Ir	dustry		
V	ithlo nan Ma	npf	Elementary/Secondary (0-12)	College (1-4or 5+))	ive kind of wo fe. DO NOT u				9					
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than neturel; or Items 23a or 28a-f show ant, Ira Madical Examination must be notified at	Ö	17.5-11-1-11-1-11-11-11-11-11-11-11-11-11-1			actory	Wor			(Fig. 4, 8 4) - 1 - 1		ay Co	rp.		
	I be fi	Be	17. Father's Name (First, Middle, Last)							e (First, Middle,		,			
2	should and Men s marke umatic	2	Edward Concannon 19a. Informant's Name/Relationship (T)	ina Print)	19h M	la ilina Address	(Street			argaret a <i>l Route Numb</i> e			Codel		
<u> </u>	01 (0 00 00		Ruth A. Hack	Daughter		-				Finksbu					
a)	of Health of Health litem 27 I		20a. Method of Disposition	Daughter	20b. Place of D					Date	20c. Location				
ē	Pages nent of I ant: If its ary or o		1 X Burial 2 ☐ Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)		Evergre				6/2	/05	Finks	hura	MD		
altimore,	permit. Page Department (Importent: If any injury or once.		21. Signature of Euperal Service Licens		Lveigie	22. Name ar							own Road		
ă	permi Depa Impo any ir		Slephon	m Jen	Kins	Eline	Fune	ral H	Iome				D 21136		
	Anysician /Medical Examiner	ner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Carges five (Heart failure) Due to (or as a consequence of): Carges five (Heart failure) Due to (or as a consequence of): Carges five (Heart failure) Due to (or as a consequence of): Carges five (Heart failure) Due to (or as a consequence of): Carges five (Heart failure) Due to (or as a consequence of): Carges five (Heart failure) Due to (or as a consequence of): Carges five (Heart failure)												
,00/00	ificate be executed g physician and as the burial-transit	edicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of)	n tery	d	roek	-0						
. DOX	The law requires that the death certific te has been signed by the attending p age 2 should be detached for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1□Live birth 2 4□Pregnant at ti 9□Unknown	Fetal death	3 ⊟Ectopic pr 5 □ Other (sp						ate of deliv Month	ery Day Year	,	
ř.	res that i igned by be detar		Part II. Other significant conditions co	ntributing to death but	not resulting in th	e underlying c	ause give	en in Part I.		23e. Did to	bacco use co	ntribute to t	he cause of death	1?	
2	quires n sign ald be	d by								1 🗆 Y	es 2□No	3 🗆 Proi	oably 4. Unkr	10 W 0	
necords,	ıw requir s been si should	Completed								24a. Was a	ın 24b	. Were auto	opsy findings avai	lable	
ב	rhe far te has age 2	шо								autop: perfor	med?	prior to co death? 1 Yes	impletion of cause	e of	
		0	25. Was case referred to medical					26. Place	of Deatl	1 ☐ Yes	2 <u>No</u>	1 1 1 1 1 1 1 1	200		
>	N S	To B	examiner?	lospital: 1 Inpatient	2 ER/Outpa	tient 3□ DC	Othe			me 5□Resid		ther (Specia	(y)		
DIVISION OF	Attending Physiclen: r death. sctor: After this certific by the funeral director,		27. Mann 1 Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	Year) 28b. Tim	e of 2	8c. Injury Work	at		28d. Describe h	ow injury occi	urred			
<u> </u>	ttendir death. ctor: Al	Certification:	2 Accident investigation			M		Yes 2□	No						
Š	l or Atten after deatl Director: I in by the	TÎ,	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc.	y - At home, farm (Specify)	, street, factory	, office			28f. Location (S City or Tow	treet and Nun n, State)	nber or Run	al Route Number,		
2	lospital of the control of the contr			1											
	Hosp 24 ho Fune tely fi	edicai	29a. Certifier 1 ✓ Certifying Phy (Check only one) 2 ☐ Medical Exami	sician: To the best of ner: On the basis of e	xamination and/o	leath occurred or investigation	at the tim , in my op	ie, date an pinion, dea	d place, th occuri	and due to the c ed at the time, c	ause(s) and r late and place	nanner as s e, and due t	tated. o the cause(s)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Med	26b. Signature and title of certifier	and manner state		290	. License	number		1 2	29d. Date sign	ned (Month.	Day, Year)		
	F 3 F 8	2	1 1-1	8 /				102	H	0	5729		/		
. /	1/1	6	30. Name and address of person who co	om leted cause of dea	1th Item 22a) /T-	ne Print)	0/								
1	0		Syed Hosair	V	44	7 F.	m	aln	St.	West	minst	er M	102115	フ	
	Sta	ite	31. Date filed (Month, Day, Year)		s Signature	la	Know	1							

Gover Anni

		•	1 - State	partment of Health and Mertificate of Death		2005	18276
			1. Decedent's Name (First, Middle, Last)	ortinoate of Beatin	Reg. N	10.000	3. Time of Death
	Physicia	an	CHARLES FRANK GROSS		Month C	8 2005	10:35A ^M
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		tc. County of Deat	
	Examin	er		Annapolis		nne Aruno	
			Hertitage Harbor Health & Rehab. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)				
	Funeral Director		218-18-1175 XX M 2 F 91 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea June 16.	1913 Mai	nplace (State or Foreign untry) CVland
			Usual Residence of Decedent		00110 10,	1010 1101	y zana
	/land		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Man	ţ	Maryland Baltimore City Balt	imore City			Y⊠Yes 2 No
	the	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Co	untry?
	3a ol		2921 Berwick Avenue	21234		USA	
	death	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13	B. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
(0	or Item	Fur	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No		Hican, etc.)	Black, White	White
8	within 72 hours after death with the Maryland ene. than "natural", or llems 23a or 28a-f show fre M. ofcal Ex. nither , ust be notified at	by	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes XX No <i>Specify:</i>		Specify:	MITCE
20	72 ho	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	cedent's Usual Occupation we kind of work done during most of work	ina 16b.	Kind of Business/	ndustry
2	within ane. than "I	혈	Elementary/Secondary (0-12) College (1-4or 5+)	. DO NOT use retired)			
2	77 75 1 1 1 1 1	ő		Manager		oss Coal	Co.
nd	be filed tal Hyg d otha event,	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Maid		
<u>ya</u>	should be and Mental Is marked o	ဥ	Charles Gross		ieffenhof		
Maryland 21215-0036	s 1 and 2 should I Health and Men Itam 27 is marke other traumatic	0.3		iling Address (Street and Number or Rura			
	s 1 and 2 of Health a itam 27 is other trai			l Berwick Avenue Ba			
ore	of Head		20a. Method of Disposition XX Burial 2 □ Cremation 3 □ Removal from State	rematory or other place)	Date 20c.	Location - City or	Iown, State
Ξ.	Pages ment of I ant: If its ury or o	10	`4 □Donation 5 □Other (Specify) Parkwood	d Cemetery 6-1-2		ltimore,	
Baltimore,	permit. Pages 'Department of Himportant: If its any injury or of one		21. Signature of Fundam Service Licensee	22. Name and Address of Facility Lassahn Funera	7 11	401 Belai	
ш_	997 2 2 2	ų š	Jan 2 June	Lassaill Fulleta	it uoile B	altimore,	md. 21236
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause in each line.	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician	ì	Immediate Cause (Final disease or condition	torelloua			Oliset and Death
н	/Medical		resulting in death) Due to (or as a consequence of):				
н	Examiner		Sequentially list conditions.				
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enail Unanglia, Cause (Disease or injury				
V	and and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):				
90,	se ex	Ē	Due (o (or as a consequence or).				
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai	d				
9 x	ertific ding p	Me	IF FEMALE: 23c. If yes, outcome of pregnancy			00 1 0 1 1 1 1 1	Ta
Вох	eath certific attending p for use as	lan	in the past 12 months?	Ectopic pregnancy		23d. Date of deli Month	very Day Year
o.	at the de by the a tached	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5	5 Other (specify)			
<u>α</u>	that til ed by detac		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ds,	signe d be	1 by	failure to House		1 🗆 Yes	2 □No 3 □ Pro	bably 4 Dunknown
Ö	w require been si should !	Completed	Discussion		24a. Was an	24h More au	toney findings available
3ec	e law has l	idu	phellouid.		autopsy performed	prior to d	topsy findings available completion of cause of
a				<u> </u>	1□ Yes 2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		2 No
Z:	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner? Hospital: Hospital:	Other	h (Check only one)		
of	Phys this	: To	1 Tes 2 No 1 Inpatient 2 EH/Outpat	ient 3 DOA 4 Nursing Ho	me 5 Residence 28d. Describe how in		city)
L C	9 ja 9	io	1 Natural 5 ☐ Pending (Month, Day Year) Injury			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
is.	E 22 0	ical	3 Suicide 6 Could not be 380 Place of Laive. At home form	40.15	28f. Location (Street	and Number or Ru	ral Route Number,
Division of Vital Records,	ial or Attandir s after death. al Director: Al ad in by the fu	Certification;	4 Homicide determined building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	City or Town, Sta	ate)	
_	To the Hospital or Atte within 24 hours after de To tha Funaral Directo completely filled in by th		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de				
	e Ho 24 h a Fui letely	Medical	(Check only one) /2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurr	red at the time, date a	and place, and due	to the cause(s)
	To th withir Fo th xompl	Me	29b. Signature and title of certifier	29c. License number	29d. I	Date signed (Monti	n, Day, Year)
)	. 2,-0) (A)	D57028		5-31-	05
	^		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)		- 110	2. 4.61
	1)		ADITUA CHOPRA IMD 600 RIDS	FLY AVE #231 A	WNAPOUS	5, MD 2	1401
	Sta	ite	31. Date filed (Month, Day, Year) 32. Degistrar's Signature	parte			
	Registi	ar	JUN 0 1 2005 Brown D. A.				

			1 - For State Registrar	State	of Mary		partment of ertificate of		nd Men		ene_200	5	182	77
	Physici		Decedent's Name (First, Midd.	e, Last)	Mabe	l Georg	e			Date of Death Month Ma	y 25, 2005 ^Y	ear	3. Time of D 4:10 p	eath M
	/Medic Examir		4a. Facility Name (If not institution	n, give street and 11 Park Ave		t 410	4b. City, Town,		Baltimore		4c. County of I	N/A		
	Funeral Director		5. Social Security Number 215-16-9998 Usual Residence of Decedent	6. Sex 1 ☐ M 2 X ☐ F		n yrs. last birthda 86 Yrs.	y) If Under 1 Yea Months Days		Min. 8. [Date of Birth Month, Day, Jan 23,	(ear) 9. 1919	Birthpla Countr	ice (State or I y) S. C.	Foreign
	Maryland -f ehow	tor	10a. State 10b. County	N/A	10	Oc. City, Town or		3altimore			*****	100	d. Inside City	
	th with the Ma 23e or 28e-f ust be notifie	al Direc	10e. Street and Number 1111 Park Avenue	- Apt 410			10f. Zip Code	2120	1	10	g. Citizen of Wha	t Countr J.S.A.	-	
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28e-f ehow importent: If item 27 is marked other then "naturel", or items 23e or 28e-f ehow hy Injury or other treumatic event, it is Mudical Exam mar must be notified at ance.	Completed by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☑ Mar 3 ☐ Widowed 4 ☐ Divorced	ried Armed 1 ☐ Ye If Yes,	ecedent Eve Forces? es 2 [X] No Gîve r Dates:	or in U.S. 13	3. Was Decedent of If Yes, specify Cu		in? (Specify Puerto Rica	Yes or No- n, etc.)	14. Race - A Black, N Specify:	White, et		
21215-0036	d within 72 h giene. ir then "natu	omplete	15. Deceder (Specify only higher Elementary/Secondary (0-12)	- i	ed) e (1-4or 5+)	(Gi	pedent's Usual Occi ve kind of work doni DO NOT use retir Foo	e during most			Bb. Kind of Busin		•	tem
Maryland ;	should be filed and and Mental Hygis marked other umatic event, II	To Be C	17. Father's Name (First, Middle,	Last) die George				18. Mother	r's Name <i>(Fir</i>		aiden Sumame) ella George			
	1 and 2 sho Health and tem 27 is ma		19a. Informant's Name/Relations Bernard Strawberry 20a. Method of Disposition	hip (Type, Print)	1,		iling Address (Stree 3101 Marlora position (Name of			laryland 2				
Baltimore,	permit, Pages 1 al Department of Hea Importent: If item any Injury or othe once.		1 🕱 Burial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (S	pecity)		cemetery, c.	rematory or other plutus Memoria 22. Name and Addi	Park	06/	03/05		nore,		
Bal	permit, Departr Importe any Inju		21. Signature of Funeral Service	m. Osto	1	Funeral S ce Baltim	Service PA ore, Md 2	21217						
8760,	Cate be executed whysician and physician and the burial-transit the bu	sal Examiner	23a. Part1. Enter the distase, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ab	to (or as a co	7.5	LNO 512	-		pictory unoc		1	Approximate interval Betwee Onset and De	
O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ੴNo 9 □ Unknown	1□Liv 4□Pre	outcome of p e birth 2 [egnant at tim	Fetal death	B Ectopic pregnan	су			23d. Date of Month		, Vay Ye	ar
rds, P.	quires that n signed b ıld be deta	by	Part II. Other significant conditi	ons contributing to	o death but n	ot resulting in the	underlying cause g	iven in Part I.		23e. Did toba	cco use contribu		cause of dea	
al Records,	The ate h page	Completed								24a. Was an autopsy performe 1 🗌 Yes 2 [24b. Wer prior deat	to comp	sy findings avoidetion of cau	railable ise of
ion of Vital	ding Phys I. After this funeral di	atlon; To Be	Z C Accident	Hospital: 1 28a. Da (M	☐ Inpatient ite of Injury lonth, Day Ye	2 ER/Outpatr 28b. Time Injury	of 28c. inju	ther: 4 🗆 Nur	sing Home 28d.		ce 6 □Other (a	Specify)		
Division	ospital or Attendours after death hours after death uneral Director: ly filled in by the	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 286. Pi	ace of Injury ilding, etc. (5	- At home, farm, Specify)	street, factory, office			ocation (Stre City or Town,	et and Number o State)	r Rural I	Route Numbe	∍r,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifyii (Check only one) 2 Medical	Examiner: On the	the best of me basis of exa anner stated	amination and/or	ath occurred at the investigation, in my	opinion, death	I place, and on occurred a	the time, dat	e and place, and	due to tl	he cause(s)	
	C To Manage To M	2	29b. Signature and title of certific	Ron mo	AHe	ndingPh		nse number	165:		1. Date signed (M) $\int 26$			
1	5		Murc Solcolow	MD 13	-	n (Item 23a) (Typ	Pierre D	rive t	生120°	Tous	nmp	2):	204	
	Sta Registr	1	31. Date filed (Month, Day, Year, JUN 0	1 2005	. Registrar's	Signature	Carles							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2005 Month Year **Physician** 28, 5:30P Charlotte Marx Geiss Mav /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Good Samaritan Hospital Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Date of Birth (Month, Day, Year) Months Days Hours 1 🗆 M Director 213-01-8710 November 27,1916 | Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Modical Examiner must be notified at 1 Yes 2 No Be Completed by Funeral Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? ō 21239 USA or Items 23e 1307 Heather Hill Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💢 🌠 olf Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes XX No Specify: White Specify XX Widowed 4 ☐ Divorced 'naturel' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Morris Frederick Marx Catherine Brandt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 418 Hillen Road Baltimore, Maryland 21286 Gary A Geiss Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XX urial 2 Cremation 3 Removal from State permit. Page Department o Important: If eny injury or once. injury or ☐Donation 5 ☐ Other (Specify) Baltimore Cemetery 6/2/05 Baltimore, Maryland ignature of Funer J.S. vice/Licensee Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Due to (or as a c Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 onths? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be reamele 2 No 3 Probably 4 Unknown Medical Certification: To Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed 1 ☐ Yes 2 No filled in by the funeral director, 25. Was case referred t examiner? 26. Place of Death (Check only one) Other: Hospital: 1 🗌 Yes 1 🗌 Inpatient 2 - R/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) s after death. 27. Mann f Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural 1 🗌 Yes 2 🗌 No 2 Accident 3 Suicide 6 Could not 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determin 4 Homicide within 24 hours a To the Hospitel 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier-29c. License number 29d. Date signed (Month, Day, Year) 2005 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person (21 GO 31. Date filed (Month, Day, Year) 32. Registra Signature State JUN 0 1 2005 Registrar

			1 - For Registrar	State of Ma	-	epartmer Ce <i>rtificat</i>				ental Hy	giene Reg. No.	005	5 18	279
п	Physici		1. Decedent's Name (First, Middle, L	ast)						2. Date of De Month	eath Day	Yea	3. Time	of Death
	/Medic		Richard	Edward	Gunth	er, Jr.				May	21	2005	8:05	р ^м
	Examir		4a. Fecility Name (If not institution, ga	ve street and number)		4b. City,	Town, or	Location (of Death		4c. 0	ounty of De	eath	
			4814 Sudley Roa	d				River				nne A	runde1	
	Funeral			Sex 7. Ag 1⊊M 2□F	e (In yrs. last birth	Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Nov • 2	rth ay, Year)	9. 8	Birthplace (State Country)	or Foreign
	Director			X	80 Yı	rs.			1	Nov. 2	7, 19	24 Ma	aryland	
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location							10d. Inside	City Limits
	sho	5	MD Anne A	rundel	West 1									s 2XXVo
	he №	ect		I GIIG C.	,,,esc 1		0.4				40 000			2671
	with t	Funeral Director	10e. Street and Number	_		10f. Zip					10g. Citiz	en of What	Country?	
	s 23	rai	4814 Sudley Roa				0778				US			
	er de Item	un.	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Dece If Yes, spe	cify Cuba	ispanic Ori in, Mexicar	n, Puerto F	Rican, etc.)	D- 1	Black, W	merican Indian, hite, etc.	
36	s aft	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠Yes 2 ☐ f If Yes, Give Year or Dates:	1941_45	1 🗆 Yes	2 ∏ No	Specify:			5	Specify:	White	
21215-0036	within 72 hours after death with the Maryland ane. then "natural", or Items 23e or 28a-1 show the Medical Examination colling at	pa	15. Decedent's 8			ecedent's Usu	al Occupa	ation			16h Kin	d of Busines	es/Industry	
5	in 72	Completed	(Specify only highest g	rade completed)	()	Give kind of wo	rk done d	turina mos	st of workin	19	100.10	or Busine.	33/mau3my	
12	filed within Hygiene. other then ent, the M	m c	Elementary/Secondary (0-12)	College (1-4or 5	i+)	stom Bu		•			B	oats		
0	filed Hygid other ent,	Ö	17. Father's Name (First, Middle, Las	t)					er's Name	(First, Middle			·	
an	ould be Mental I sarked o	8	Richard E. Gun	ther. Sr.				Gen	ieve	Wells				
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. item 27 is marked other then "natural", or items 23e or 28e-1 show other traumetic event, the McJical Exarians I must be refilled at	ဥ	19a. Informant's Name/Relationship		19b. N	Mailing Address	(Street a				er. City or	Town State	a. Zin Code)	
≥	nd 2 s lith ar 27 is 27 is		Lillian E. Gunt			14 Sudl							,	
a)	ges 1 and t of Health If item 27 or other to		20a. Method of Disposition	Her (WITE)	20b. Place of D	Disposition (Nar	ne of			RIVEI :			or Town, State	
Baltimore,	permit. Pages 'Department of Informant: If ite any injury or of once.		1X Burial 2 ☐ Cremation 3		1	crematory or o			E /26	/2005				
큹	rtme rtant njury	1	* 4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice		Marylar				5/26/			vnsv1.	lle, MD	
Ba	Depa mpo my i		21. Signaturabi Funeral Serece Lice	(h		Hard	esty	Fune	ral F	Home, I	P.A.			
	20244				N - d - N - D			_		Annar		MD 2		
н			23a. Part1. Enter the disease, or cor shock, or heart failure. List ont	one cause on each lin	the deeth. Do no 18.	t enter the mod	ie or ayını	g, such as	cardiac or	respiratory a	irrest,		Approxima Interval Be Onset and	tween
E	Physician	13	Immediate Cause (Final disease or condition	_ a	ung	Car	10€	V					Ino	っせい
П	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):								
	Zammer	L	Sequentially list conditions,	b										
	pg tis	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):								
	and -tran	кап	that initiated events resulting in death) Last	C. Due to (or as	a consequence of									
80,	The taw requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Ē		Due to (or as	a consequence or,									
8760,	physic the b	lical		_ d.									-	
9	leath certifica attending ph d for use as th	Physician/Med	IF FEMALE:											
Вох	ath ce ttend or us	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth	of pregnancy 2 □ Fetal death	3 □Ectopic pr	egnancy				23	d. Date of o	delivery Day	Year
0	e de	sic	1 ☐ Yes 2 ☐ No	4☐Pregnant at 9☐Unknown	time of death	5 Other (sp	ecify)				1	100000	Day	i Gai
Q. Q.	at the de d by the a stached	Phy	9 Unknown							T				
Ś	res that igned to be deta	b	Part II. Other significant conditions	contributing to death bi	ut not resulting in t	he underlying c	ause give	n in Part I.	•	1	_		to the cause of	
Vital Records,	w require been sig should t									100	Yes 2□	No 3□	Probably 4	Unknown
ပ္ထ	e taw r has be je 2 sh	pie								24a. Was			autopsy findings o completion of	
ď	The ate had page	Completed									rined? 2X No	death' 1 □ Y	?	5443G 5.
ita	iclan: Th certificate rector, pag	O	25. Was case referred to medical					26. Place	of Death	(Check only	1			
>	Physician: this certifica al director, i	B	examiner? 1 ≥ Yes 2 □ No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outp	atient 3 DC	Othe	er: 4□Nu	ırsing Hom	e 5 Tesi	dence 6	□Other (St	pecify)	
		늘	27. Mamer of Death	28a. Date of Injui (Month, Day	y 28b. Tin Year) Inju	ne of 2	8c. Injury Work	at		8d. Describe	how injury	occurred		
<u>ö</u>	를 구 를 끌	atio	Natural 5 Pending 2 Accident investigation		roar/ inju	M		res 2 🗆 l	No					
Division	Attence or death ector: by the	Certification:	3 Suicide 6 Could not determined		iry - At home, farm	n, street, factory	, office		2	8f. Location (City or To		Number or	Rural Route Nur	nber,
Ö	el or At s after c il Direct od in by	ē	4 I Homodo	bullding, etc	(Эрөспу)				1	Ony or To	wii, Siate)			
	To the Hospitel or a within 24 hours after To the Funerel Dire completely filled in b		29a. Certifier Certifying P	hysicien: To the best	of my knowledge, o	death occurred	at the tim	e, date an	d place, a	nd due to the	cause(s) a	nd manner	as stated.	
	n 24 n 24 ne Fu	Medical	(Check only 2 Medical Exa	miner: On the basis of and manner sta	examination and/ ted.	or investigation	, in my op	inion, dea	th occurre	d at the time,	date and p	lace, and d	ue to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier			290	. License	number			29d. Date	signed (Mo	nth, Day, Year)	
	1		Klenine	Weine	, MD		DS	283	30		May	25	,2000	1
•	()		30. Name and address of person who	completed cause of de	eath (Item 23a) (To	ype, Print)		_ 0 =					-	
1			Jeanine Werr	WIMD "	700 Beck	Gate	Roa	al #	300	An	ra po	15.M	10 21	401
	Sta	te	31. Date filed (Month, Day, Year)	32 Registra	r's Signature	Acod's				1		11/50		7 - 1
	Registr		30. Name and address of person who I can me and a can me a ca	005	1 10. A	The state of the s								

			For Stata Registrer	State	of Marylan	d / Depa		t of H	lealth a	and M		giene Reg. No.	005	18280
	Physicia	an	Decedent's Name (First, Middle Albert	e, Last)			Hopki:	nc	Sr		2. Date of De Month 5-30		Year	3. Time of Death 6:34p M
	/Medic Examin		4a. Facility Name (If not institution	n, give street and nu	imber)				r Location of	of Death	3-30		County of Dea	
	L.Xaiiiii	iei	2730 E. Chas	-				Bal	Ltimor	ce			NA	Δ
	Funeral Director		5. Social Security Number 218–22–1099	6. Sex 1 X M 2 X F	7. Age (In yrs. 79	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 5–4-	th 14. Year) 25	9. Bi	rthplace (State or Foreign ountry)
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	ocation							10d. Inside City Limits
	a-f sh	ctor	Md.	NA		Bal	timor	e						X □Yes 2□No
	vith tha	Director	10e. Street and Number	Chanat			10f. Zip		21213			10g. Citiz	en of What C	ountry?
	ns 23g	Funeral	2730 E. Chase		edent Ever in U.	S. 13.	Was Deced			ain? (Spe	acify Yes or No		4. Race - Am	erican Indian,
တ္တ	ba filed within 72 hours after death with the Maryland tal Hygiene. id other than "naturel", or lams 23a or 28a-f show event, I've Medical Examinat must be notified at	/ Fun	1 Never Married 2 Mar	Armed F ned 1 ☐ Yes If Yes, G	orces? 2.⊠No		If Yes, spec 1 ☐ Yes 2		an, Mexicar Specify:		ecify Yes or No Rican, etc.)		Black, Wh Specify: F	ite, etc. Black
003	hours tural',	d by	3 Widowed 4 □ Divorced	Year or I	Dates:									
15	in 72 n "nat	olete	(Specify only highe	it's Education st grade completed,		(Give	dent's Usua kind of wor DO NOT us	rk done se retired	ation du <i>ring m</i> os d)	t of worki	ing	16b. Kin	d of Business	s/industry
212	a filed withi al Hygiene. othar than vant, I'm N	Completed	9th grade	College	(1-4or 5+)		Labor	er				Bet	hleher	n Steel
Maryland 21215-0036		Be	17. Father's Name (First, Middle,	Last)	77 1- 3					er's Name tlie	e (First, Middle	, Maiden S	Sumame) Curbe	aan
Ŋ	d 2 should ba th and Mental ?7 Is marked of traumatic eve	J.	Charlie 19a. Informant's Name/Relations	ship (Type, Print)	Hopkins		na Address	(Street			al Route Numb	er. City or		
	12 7 Is		Fred Hopkins	Brot	her		-				mit, N		07901	
Baltimore,	S to L		Da. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 1 XBurial 2 Cremation 3 Removal from State Wostonn Star Com 1 XBurial 2 Cremation 3 Removal from State								Date		ation - City o	
Ë	mit. Pages partment of h ortant: If Its injury or of	'4 □Donation 5 □Other (Specify) Western Star Cem								5–3–0				le, Md.
Bal	permit. Page Department. Important: If any injury o		21. Signature of Funeral Service	st	Balt 1101	imor	e, Md. North	21202 Ave.						
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that only one cause on	caused the death each line.	n. Do not en	ter the mode	e of dyin	ig, such as	cardiac (or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical	ė ii	Immediate Cause (Final disease or condition resulting in death)	a	(or as a conseq	hyThi	4							sew-15
A	Examiner			Due to		uence of):		22						months
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ursease or injury	b. Due to	(or as a conseq									
	ecutec and -transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a consequ									-
60,	ba executed sician and burial-transit	cal E		Due to	(or as a consequ	uence or).								
68760,	ificate t g physical as the k			d										
P.O. Box	at the death cartificate ba executed by the attending physician and tached for usa as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	atcome of pregna birth 2 ☐ Feta mant at time of de nown	Ideath 3[□Ectopic pre □ Other (<i>sp</i> e		/			2:	3d. Date of de Month	alivery Day Year
	es that igned by be deta	by Pr	Part II. Other significant conditi	ons contributing to				ause giv	en in Part I		23e. Did t	obacco us	se contribute (to the cause of death?
ords	w require been sig should b			cinh	utes n	relli r	v;				1 🗆	Yes 2□]No 3□F	robably 4 Honknown
I Records,	The lay ate has page 2	Completed									24a. Was auto perfo 1 Yes	psy ormed?	24b. Were a prior to death?	utopsy findings available completion of cause of s 2 No
Vital	Physician: Th r this certificate ral director, paç	Be	25. Was case referred to medica examiner?	Hospital:				Oth			(Check only o			
of	Phys this ral dii	.: To	1 Tes 2 No 27. Manner of Death	1 1		ER/Outpatier 28b. Time o					me 5 Resi 28d. Describe			ecify)
ion	Attanding I r death. actor: After by the funar	atlon	1 ☐Natural 5 ☐ Pendii 2 ☐ Accident investi	.9	of Injury oth, Day Year)	Injury	М	8c. Injur Wor 1 □	k? Yes 2□					
Division		Certification;	3 Suicide 6 Could determ	aiaaa 288, Plac	e of Injury - At ho ling, etc. (Specil)	ome, farm, str	reet, factory	, office			28f. Location (City or To		Number or F	fural Route Number,
	To tha Hospital o within 24 hours af To tha Funaral D completely filled in	edical C	29a. Certifier 1 Certifyin (Check only one) 2 Medical	ng Physician: To the Exeminer: On the I	e best of my kno basis of examina oner stated.	wledge, deat tion and/or in	h occurred a vestigation,	at the tir	ne, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s) a	and manner a place, and du	is stated. e to the cause(s)
	To th withir To th comp		29b. Signature and title of certifie	Jory	M				e number	3				th, Day, Year)
3	1		30. Name and address of person	who completed cau	ise of death (Item	23a) (Type,	Print)	٥	Balt	· (~~)	(m)	2 (7	wz	-
	Sta Registr		31. Date filed (Month, Day, Year	IN 0 1 200!	Registravs Signa	iture &	Son	uli	,					

			1 - For State Registrar	State of Maryland / De	partment of Health and Pertificate of Death	*	ne 2005 10001
	Physic		Decedent's Name (First, Middle, Las WILLIAM	it)	HOWARD	2. Date of Death Month MA 2 2	Day Year 3. Time of Death 2005 1828 M
	/Medi Examii		4a. Facility Name (If not institution, give	KINS HOSPITAL	4b. City, Town, or Location of Dea	CITY	4c. County of Death
	Funeral Director		5. Social Security Number 6. Social Security Number 6. Social Security Number 5. Social Security Number 6. Social Security	ex 7. Age (In yrs. last birthda	Months Days Hours Mir		9. Birthplace (State or Foreign Country) Md.
	72 hours after death with the Maryland naturel', or itams 23a or 28a-f show Jical Exarturar must be notified at	Director	Md. 10b. County Md. 1 10e. Street and Number	10c. City, Town or	Saltimore 10f. Zip Code	10g. (10d. Inside City Limits 1
	s 23a	ral	301 Mason Cou		21231		USA
5-0036	s 1 and 2 should be filed within 72 hours after death with f Health and Mental Hygiene itam 27 is marked other than "natural", or itams 23a or other traumatic avant, "In Medical Examinating that Le	by Funeral	11. Marital Status 1 □ Never Married 2 □ X Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 Yes 2 No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
15-0	n 72 hours "natural", guical Ex	Completed	15. Decedent's Ed (Specify only highest gra		cedent's Usual Occupation ive kind of work done during most of wo a. DO NOT use retired)	orking 16b.	Kind of Business/Industry
2121	e filed within al Hygiene. I other than "	ошо	Elementary/Secondary (0-12) 8th	College (1-4or 5+) NA	Laborer		onstruction
Maryland	2 should be file and Mental Hyg is marked othe sumatic avant,	To Be C	17. Father's Name (First, Middle, Last) William	Howard	Edna	me (First, Middle, Maid	Snell
Mar	nd 2 shallth and 27 is m	1 8	19a. Informant's Name/Relationship (7 Lottie Howard		ailing Address <i>(Street and Number or R</i> L Mason Court , Bal		y or Town, State, Zip Code) 21231
Baltimore,	0 0 == =		20a. Method of Disposition 15 Burial 2 Cremation 3 4 Donation 5 Other (Specify	20b. Place of Dis cemetery, c	sposition (Name of rematory or other place)	Date 20c.	Location - City or Town, State Randallstown, Md.
Balti	perrit. Pag Dep rtment Important: any injury o		21. Signature of Funeral Service Licens	KING ME	em. Park 6- 22. Name and Address of Facility March F.H. East		ore, Md. 21202
8760,	American and hysician and hysic	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and land cause. Enter Underlying Cause (Disease or injury	a. PNEUMON Due to (or as a consequence of):		c or respiratory arrest,	Approximate Interval Between Onset and Death Two weeks
P.O. Box 6	The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		3□Ectopic pregnancy 5□ Other (specify)		23d. Date of delivery Month Day Year
	uires that signed b	by	Part II. Dther significant conditions co	entributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Vital Records,		e Completed	25. Was case referred to medical			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
of Vi	× 50 0	To B	examiner?	Hospital: 1 Inpatient 2 ☐ ER/Outpati		ath (Check only one)	6 □Other (Specify)
Division o	ding T. After fune	Certification:	27. Manner of Death 1 Natural 2 Accident 5 Pending investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at	28d. Describe how inj	
Divi	i Sir fe		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)		City or Town, Sta	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one) Certifying Phy 2 Medical Exami	sician: To the best of my knowledge, de- iner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	a, and due to the cause(urred at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
)	withi To I	W	29b. Signature and title of certifier 307613	STON, Medical Doc	tor RES-00	0 1	ate signed (Month, Day, Year) A 9 29 2005
			30. Name and address of person who con BORIS NRISTOV TH	ompleted cause of death (Item 23a) (Type NE JOHNS HOPKINS HE	e, Print) PSPITAL GOON.WULF!	E STREET BY	SCTIMORE MARYLAND 21237
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	1 Sparle		LINIT.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0:31 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARE SHOTTOWN WINCHESTER FUTURE BALTimok B DITIMORS 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, 9. Birthplace / Country) **Funeral** 1□M 250F 8 214-20-4289 Director an Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
snt: If Item 27 is marked other than "naturel; or Items 23e or 28a-f show Lry or other treumatic event, I'm Medical Evantian Instituted at 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits Director 1 No 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1209 2121 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) osmato 00 17. Father's Name (First, Middle, Last) To Be 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) allo Marns 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages I Department of H Importent: If Ite any injury or ot once. 1 Surial 2 Cremation 3 □Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Thomas 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final **Physician** ACUTE disease or condition resulting in death) Due to (or as a consequence of): /Medical SUDDEON Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed CHEM. 15 the attending physician and hed for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown ģ ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Y 24a. Was an this certificate has autopsy performed? Yes 2 No 1 Yes filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred the Hospitel or Attending I hin 24 hours after death. the Funerel Director; After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 513/4 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 1 2005 Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	Marylan		artmen rtificat				lental Hyg	giene	05	1828	83
П	Physici	an	1. Decedent's Name (First, Middle,	Last)			-				2. Date of Dea Month	ith Day	Year	3. Time of [Death
	/Medic		Harry Donald Ho										2005	9:00	A M
	Examir	ner	4a. Facility Name (If not institution,	,	ber)		4b. City,		Location of	of Death		4c. Co	unty of Death		
			1103 Francis Av		. Age (In yrs. I	last hirthday)	If Under	Re1	ay If Under	24 Hrs.	8. Date of Birth		Balti		
	Funeral Director		217-12-8083	1 XM 2□ F	80		Months	Days	Hours	Min.	Oct. 2,	Year) 1924	9. Birth Cou	place (State or ntry) y Land	Foreign
	D		Usual Residence of Decedent										1141	, Lana	
	arylar show	Ē	10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City	
	he M	Director		timore			Rela							1 🗌 Yes	2V_1No
	with I	급	10e. Street and Number 1103 Francis Av	zenue			10f. Zip		21227		1		of What Cou ted Sta		
	ms 23	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.	S. 13.1	Was Deced				ecify Yes or No-		Race - Ameri		
စ္	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show is Madical Exeminan mast be notified at	Fur	1 Never Married 2 Married	Armed Force	□ No		fYes,speo 1 □ Yes :			i, Puerto	ecify Yes or No- Rican, etc.)		Black, White,	etc.	
8	hours ural',	d by	3 Widowed 4 □ Divorced		es: 4 <u>-43</u>		1 1 1 1 1 1 1	2 1231 NO	Specify:			Spi	ecify: V	Vhite	
5	"nat	lete	15. Decedent's (Specify only highest			16a. Deced	dent's Usua kind of woi DO NOT us	I Occupa k done d	ition luring mos	t of work	ing		of Business/In	dustry	
77	iene.	Completed	Elementary/Secondary (0-12)	College (1-4	tor 5+)	<i></i> 0. 1	Rail		,			B & (Rail:			
פַ	e filec al Hyg othe vent,	Bec	17. Father's Name (First, Middle, La	st)					18. Mothe	r's Name	(First, Middle, i				
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23s or 28s-f show apprintury or other treumetic event, the Madical Examinant be notified at once.	To	Harry Z. Househo	older					Eth	el S	impson				
Jar	2 short and last many lest	l j	19a. Informant's Name/Relationship								d Route Number			Code)	
e,	1 and Health Sm 27 ther t		Karen Bittings 20a. Method of Disposition	Daughter	20h Pi	1103			Aven		Relay, N				
no D	ages int of l t: If it	١,	1 Burial 2 ☐ Cremation 3		ate Ce	emetery, cren	natory or o	ther place					on - City or To Lmore,		
altimore,	artme orten injury	1	21. Signature C Funeral Service	Donation 5 Other (Specify) Loudon Park Cemetery 6-											
ä	Dep Imp eny	1	A DUNG H) WW	UK						Rd., An				
	-,>		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cau	ised the death	. Do not ente	er the mode	of dying	, such as	cardiac c	r respiratory arre	est,		Approximate Interval Between	990
	Pnysician	8 1	Immediate Cause (Final disease or condition			rotic	Coror	arv	Vasci	ular	Disease	<u>.</u>		Onset and De Years	ath
	/Medical Examiner		resulting in death)	Due to (or	as a consequ	ience of):					Diocase			icars	
	_xummer	-	Sequentially list conditions,		ertensi									Years	
6	uted insit	nlne	Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury	1 1000 100 (02)	on a nomeon	rankra ioty									
o o	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequ	ience of):	_								
8760,	ate he	dical		d											
õ ×	leath certific attending pl	Med	IF FEMALE:												
ROX	attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?		me of pregnar h 2 ☐ Fetel nt at time of de	death 3	Ectopic pre						Date of delive Month	ery Day Yea	ar
o .	at the de by the a tached	nysk	1 Yes 2 No 9 Unknown	9 Unknow		Ja(1) 5	Other (spe	эспу)							
ŭ,	requires that the	by PI	Part II. Other significant conditions	contributing to deat	th but not resu	Iting in the un	derlying ca	use give	n in Part I.		23e. Did tob	acco use c	ontribute to th	e cause of dea	ath?
ecords,	w require been sig should b	ted t									1 □ Ye	s 2 🗆 No	3 ☐ Prob	ably 4 ∭Uni	known
ပို	> 12 (0	ompleted									24a. Was ar	24	b. Were auto	osy findings ava ripletion of cau	allable
r =	: The lav cate has	Con									perform	neyd? ∤	death?	2□ No	00 0.
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 Yes No	Hospital:							(Check only one			-	
	iding Phys th. After this funeral dir	To To	27. Mapner of Death	1 ☐ Inp 28a. Date of I (Month,		ER/Outpatient 28b. Time of		Bc. Injury	· 4 □ Nur at		ne 5 Reside 8d. Describe ho)	
0	r Attending I er death. rector: After by the funer	atlor	1 Accident 5 ☐ Pending investigati		Day Year)	Injury	М	c. Injury Work' 1 Y	? es 2 □ N			,,			
DIVISION	r Atte er dea recto	ertiflcation;	3 Suicide 6 Could not determine	d 286. Place of	Injury - At hor , etc. (Specify)	me, farm, stre	et, factory,	office		2	Bf. Location (Str City or Town		mber or Rura	Route Numbe	er,
5	spitel or Atten ours after deat nerel Director; filled in by the	O													
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier 1X Certifying I (Check only one) 2 Medical Ex-	Physician: To the be aminer: On the basi and manner	s of examination	vledge, death on and/or inv	occurred a estigation,	t the time in my opi	e, date and nion, deatl	l place, a h occurre	nd due to the ca d at the time, da	use(s) and te and plac	manner as st e, and due to	ated. the cause(s)	
	To the Hos within 24 h To the Fur completely	Med	29b. Signatule and title of certifier	and mailing	stated.		29c.	License	number		29	d. Date sig	ned (Month, I	Day, Year)	
	->		Horse	note on				DO	05991	4		June			
	6		30. Name and a ss of pe on wh	eted cause of	of death (Item :	23а) (Туре, Р	Print)		-						
				20 N. Rol			altim	ore,	MD 2	21228	3				
	Star Registra	-	31. Date filed (Month, Day, Year)		istrar's Signatu		1	# 1							
	riegisti		19 934	0 1 2005	lie	1	done								

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

<i>I</i>	State of Maryland / Department of Health and I Certificate of Death	2005 10001
3	1. Decedent's Name (First, Middle, Last)	Reg. No. 2. Dete of Deeth 3. Time of Death
Physicia	JOSEPH HARTLOCK	Month Day Year MAY 28 2005 (0:15) PM
/Medica	4. F. W. M	
	Manor Care Rossville Rosed	ale BALTIMORE
	5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. OLG 12 1	8. Date of Birth (Month, Day, Yeer) 9. Birthplace (State or Foreign Country)
E	Usuel Residence of Decedent	12-21-23 Virginia
yland	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
a-f st	MD BALTIMORE Packville	1 □ Yes 2 Syl
with the Maryla or 288-1 show	10e. Street end Number	10g. Citizen of What Country?
ath w	7821 Shepherd Arg. 21234	USH
d 21215-0020 filed within 72 hours efter death with the Maryland Hygiene. Ther then "naturel", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	11. Marital Status 12. Was Decedent Ever in U,S. Amed Forces? 1 □ Never Married 12. Was Decedent Ever in U,S. Amed Forces? If Yes, specify Cuban, Mexican, Puerlum 1 □ Never Married	pecify Yes or No- p Rican, etc.) 14. Race - American Indian, Black, White, etc.
020 OSO OSO OSO OSO OSO OSO OSO OSO OSO OS	3 Widowed 4 Divorced 1 Yes 2 No Specify:	Specify: (1) hite.
21215-0020 d within 72 hours et giene. rr than 'natural', or tra Medical Exam.	15. Decedent's Education 16a. Decedent's Usual Occupation	16b. Kind of Business/Industry
5 / 2 121215-0 ed within 72 ho ygiene. natur it, the Medicall	(Specify only highest grede completed) (Give kind of work done during most of work done during	and P-1-
A 21		Machine lasts.
and and and and and and and and and and		ne (First, Middle, Malden Surname)
Maryland 2 d 2 should be filed th and Mental Hygis 7 is marked other if traumatic event, If		rel Route Number, City or Town, Stete, Zip Code)
e, Marylai and 2 should bleath and Menti m 27 is marked her traumatic e	Gloria Hactork 1801 Shopherd Ave	Pockville MN 21234
	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
imor Pages ment of h	1 DeBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	4 1-1-05 Rosedale, MD
Baltin Permit. P Departme Importan any Injure	21. Signature of Funeral Service Licensee 22. Name and Address of Facility	RE, MD 21234.
B Popularia	KINDY U. G. VINETUL EVOUS ELLONG C	capel, SXX Hartord Rd.
A 1	23a. Part 1. Enter the disease, or complications that crused the disease, or heart failure. List only one cause one of hine.	or respiratory arrest, Approximate Interval Between
hysician		Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a.	1
	Due to (or as a consequence of):	3
5), Symptomic of the control of the	Sequentially list conditions Due to (or as a consequence of):	i i
O, O, O, O, O, O, O, O, O, O, O, O, O, O		
68760, filtrate be executed as the burial-transit edical Examin	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
A GR	Hypothyonichson	
Box (eath certif		
15, P.O. Box res that the death certified by the attending be deteched for use a by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of deeth?
S, P. S, that the sest that t	Prophete Cancer Patres port Radiation	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Division of Vital Records, P.O. Box 687 or Attending Physician: The law requires that the death certificate effer death. Division of Vital Records, P.O. Box 687 or Attending Physician: The law requires that the death certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the ertification: To Be Completed by Physician/Medic:	Provincte Cancer Protes port Radiation Conconvermen accident	24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to
al Record The law requir cate has been s page 2 should	- Convince vacciary	performed? available prior to completion of cause of death?
The law ate has page 2		1 Yes 2 No 1 Yes 2 No
of Vital Re nystclan: The la nis certificate has director, page 2	25. Was case referred to medical examiner? 26. Place of Dear	th (Check only one)
ision of Vital Retreated by the tuneral director, page 2 ythe funeral director, page 2 direction: To Be Comp	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Ho	ome 5 Residence 6 Other (Specify)
Sion of the funer the funer cation:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending (Month, Dey Year) 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
isio ittendi death ctor: A y the fi	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Street and Number or Rurel Route Number,
Diversity of the birth of the b	4 Homicide determined building, etc. (Specify)	City or Town, State)
Hospital Puns et hours et hours et stely filled	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place,	and due to the cause(s) and manner as stated.
Division of the Hospital or Attending Plantin 24 hours effect feath to the Funeral Director. After the completely filled in by the funeral Medical Certification:	(Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occur and manner stated.	red at the time, date and place, and due to the cause(s)
To # To William	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Dey, Year)
N K) July ma D31464	5/29/05
1071	30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)	117E 308 BOUL MD 420
		117E 308 BOUT MP 4/20
State Registrar	31. Date filed (Month, Day, Yeer) 32. Registrer's Signature JUN 0 1 2005	

DHMH 16 Rev 6/95

		1_ For State		epartment of Health and Mo	ental Hygier	ne 0.05	18285			
		Registrar 1. Decedent's Name (First, Middle, Last,		Permicale of Deam	Reg. P	10:	3. Time of Death			
Physic /Med		FILDIN C	Huy JR		Month [Day Year 5 2005	540pm			
Exam		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		c. County of Death				
	U	STELLA MA	215	TIMONIUM		BALTIN	ORE			
Funera		5. Social Security Number 6. Sec 215 · 65 · 748	7. Age (In yrs. last birtho	Months Days Hours Min	8. Date of Birth (Month, Day, Yea	ur) Coun	lace (State or Foreign try)			
Directo		Usual Residence of Decedent	10	3.	6.27.	1914 M	RYLAND			
ryland how		10a. State 10b. County	10c. City, Town o	or Location		1	Od. Inside City Limits			
e Ma	Director	MD BALTIN	lore Art	Butus			1 ☐ Yes 2 🗷 No			
with the sor 2 to 2		10e. Street and Number	0 75	10f. Zip Code	10g. (Citizen of What Coun	itry?			
eath v	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	21227	offy Vos or No	14. Race - Americ	an Indian			
fter d	FL	1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ No	 Was Decedent of Hispanic Origin? (Spe- If Yes, specify Cuban, Mexican, Puerto F 	Rican, etc.)	Black, White,				
ours a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: WH	TIE			
and 21215-UU36 be filed within 72 hours after death with the Maryland stat Hygiene. dother than "natural", or items 23a or 28e-f show event, its Madical Exeminat must be notilized at	Completed	15. Decedent's Edu (Specify only highest grad	le completed) (C	ecedent's Usual Occupation Give kind of work done during most of workin	ng 16b.	Kind of Business/Inc	dustry			
within within than than	ld III	Elementary/Secondary (0-12)	College (1-4or 5+)	ife. DO NOT use retired)	I	NSURAN	CF			
filed Hygis	ပိ	17. Father's Name (First, Middle, Last)	1		(First, Middle, Maid					
aryland 2 should be filed nd Mentat Hygi marked other umetic event, 1	To Be	EDWO C.	LILL KR	(1)	NKWai	S				
00 % % e 2		19a. Informant's Name/Relationship (Ty	гре, Print) 19b. М	Mailing Address (Street and Number or Rura	l Route Number, City	y or Town, State, Zip	Code)			
		CHARLES MEYER,	NEPHEN 35	OG ORBITAN R			MD 21234			
Pages 1 nent of H int: If ite		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ F	Removal from State cemetery,	isposition (Name of crematory or other place)		Location - City or To				
Line Pa		'4 □ Donation 5 □ Other (Specify)		SON FOREST	- I A	STERTOW Z OF MEM	D.MD			
Balt permit. Depart Import eny inj		21. Signature of Funeral Service Licens	Mayaaa	22. Name and Address of Facility	-					
		23a. Part1. Enter the dillame, or compl	ications that caused the death. Do not	t enter the mode of dying, such as cardiac or		CILLE, I	ND Z1234 Approximate			
Physiciar		Immediate Cause (Final	ne cause on each line.				Interval Between Onset and Death			
/Medica	_	disease or condition resulting in death)	Due to (or as a consequence of).	CTED PULMONARY DISEAS	SE					
Examine		Sequentially list conditions	b							
P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to (or as a consequence of):							
ecute and I-trans	Examiner		c							
8760, ate be executed hysician and the burial-transit				•						
ate ate	edical		J							
BOX 61 leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	2 Tetorio regrando.		23d. Date of delive	ry			
death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year			
ecords, P.O. law requires that the de as been signed by the a 2 should be detached 1	Phy	9 Unknown								
0 8 5 6	by	Part II. Other significant conditions con	use contribute to the cause of death?							
w requ	etec				-					
A 0 - 6	Completed				24a. Was an autopsy performed?	prior to con	osy findings available apletion of cause of			
_ F # 6	e Co	25. Was case referred to medical		26. Place of Death	1 ☐ Yes 2 X 1		2 No			
00	OB	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	Othor		6 NOther (Specify	HOSPICE			
ON OI ding Ph h. After th funeral	n: T	27. Manner of Death 1 XNatural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Tim	ne of 28c. Injury at 2	8d. Describe how in		, MODI IOI			
ision ttendir death. ctor: Af	catle	2 ☐ Accident investigation	.,,	M 1 ☐ Yes 2 ☐ No						
DIVISION OF I or Attending Phy after death. Diractor: After this In by the funeral d	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	i, street, factory, office 2	8f. Location (Street City or Town, Sta	and Number or Rura ate)	Route Number,			
DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
To the Hospital within 24 hours a To the Funeral completely filled	Medical	(Check only 2 Medical Exami	ner: On the basis of examination and/o and manner stated.	prinvestigation, in my opinion, death occurre	and due to the cause and at the time, date a	(s) and manner as stand due to	ated. the cause(s)			
To the within 2 To the complet	¥	29b. Signature and itle of certifier		29c. License number	29d. [Date signed (Month, L	Day, Year)			
	1	1		D43721		5/26/	105			
10		30. Name and address of person who co	ompleted cause of death (Item 23a) (Ty	ype, Print)		1				
\		DR. TARIQ MAHMOOI		LLEY RD. TIMONIUM,	MD 21093					
S Regis	tate trar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	in a facility						

ORIGINAL

5:40 р.ш.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 10:20 A^M 27, 2005 William Marlin Haughey May /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 1204 Edmondson Avenue Catonsville Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months 1**⅓**M 2□F Yrs. **Director** 215-10-6975 83 1921 Maryland Usual Residence of Decedent e filed within 72 hours after death with the Maryland Il Hygiene. orber than "natural", or Items 23e or 28e-f show vent, I're Medical Exercities man be recilified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Maryland Baltimore Catonsville Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USĄ 1204 Edmondson Avenue <u> 21228</u> Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Tyes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Accounting 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill Health and Mental H tem 27 is marked oth C. Jesse Haughey Marguerite Darg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health a ant: If Item 27 is Wife 1204 Edmondson Avenue; Catonsville, Maryland 21228 Doris M. Haughey or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page Department o Important: If any injury or once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 5/31/2005 Beltsville, Maryland 1 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licenses Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** hepatoma

Due to (or as a consequence of): aweeks /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? β 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe rmed? 2.X.No 2 No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home SER Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 EN/Outpatient 3 DOA hours after death. uneral Director: After this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number P35254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD 21220 900 ave arole 31. Date filed (Month, Day, Year) 22 Ragistrar's Signature State 1 Registrar

DHMH 17 Rev 1/2001

in Black Indelible Ink. Ensure All Copies Are Legible.
OC 849 II-15-05 vt
Iland / Department of Health and Mental Hygiene
In G844 6-8-05 tas
Certificate of Death Please Type or Print in Black Ind Amend item I per doc 8649 I. State of Maryland / Depar State of Maryl State of Maryl Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Kent Harper Jr. Laurence Day 2005 Year **Physician** JUNE 1, LAWRENCE KEMP HARPER JR. 1:00a M /Medical 4c. County of Death BALTIMORE 4a. Facility Name (If not institution, give street and number, Town, or Location of Dea STEVENSON Examiner 308 GOLF COURSE ROAD | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | DEC • 26, 7. Age (In yrs. last birthday) 85 6. Sex Social Security Number Birthplace (State or Foreign
Country) **Funeral** 1 **X**M 2 □ F 215-12-8431 1919 MARYLAND Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehov traumatic evant, the Medical Examiner must be notified at BALTIMORE STEVENSON ~ MD 1 Yes X No Directo Florida Collier **Naples** 10g. Citizen of What Country? USA 10e. Street and Number 10f. Zip Code 5 308 COLF COURSE ROAD 107 Club-House Lane Apt.190 or Items 23a 34105 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status filed within 72 hours after Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: WHITE þ Specify: 3 X Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygient Important: If item 27 is marked other that any injury or other traumatic evant, Ing. 2008. STOCK BROKER STOCK BROKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be KATHERINE HARDY ဂ္ LAWRENCE KEMP HARPER SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) LAWRENCE HARPER son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State JUNE 2/12005 GREEN MOUNT BALTIMORE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 21. Signature of Funeral 16924 YORK ROAD MONKTON, MD 21111 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate terval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) letas tatic **Physician** years /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of) physician Physician/Medical the t IF FEMALE: nse s 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctooic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 □ Yes 2 19 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes I or Attanding Physicien: after death. Diractor: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No ٥ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital of within 24 hours at 10 the Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760

P.O. |

Division of Vital Records.

ORIGINAL

6301

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Connell

32. Registrar's Signature

D.

31. Date filed (Month, Day, Year)

Ba/ som

			For State Registrar	State of I	Maryland	•	rtment o			d Mental Hy	giene Reg. No.	2005	18282
	Physici		1. Decedent's Name (First, Middle, Last) 2. Dolores Mae Hindle							2. Date of De May 26,			
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Good Samaritan Nursing Center Baltimore							eath	4c. County of Death		
	Funeral Director			x 7. □ M 2□YF	Age (In yrs. Ia 71	st birthday) Yrs.	If Under 1 Y Months Da		Jnder 24 h burs N	Hrs. 8. Date of Bir Month, Da April 5	1934	9. Birth Mary 1	place (State or Foreign intry) and
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Baltimo	re	10c. City,	Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23a or 28 ust be nut	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Cit 13225 Fork Road 21013								zen of What Cou	ntry?	
	172 hours after death with the Marylan "natural", or Hems 23a or 28a-f show idical Examilies must be mullised at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s? X) No	1	Vas Decedent f Yes, specify	Cuban, Me	nic Origin? exican, Po pecify:	(Specify Yes or No Jerto Rican, etc.))-	14. Race - Ameri Black, White Specify: Whi	, etc.
	be filed within 72 hc tal Hygiene. d other than "natur event, Ire Medical	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)		or 5+)	(Give life, L	lent's Usual O kind of work d OO NOT use re	bne during etired)	g most of	working		ind of Business/Ir ederal Gov	
Maryland 2	ed la b	To Be C	17. Father's Name (First, Middle, Last) Herbert F. Coard, S	·.				18. E	Mother's	Name (First, Middle Evans			
	d2: th ar trau		19a. Informant's Name/Relationship (7 Herbert F. Coard, Jr. 20a. Method of Disposition	•	20h Pla	13225		nd Ba		Maryland 2	1013	r Town, State, Zi	
Baltimore,	Page ent o nt: If ry or		1 X Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen)	Park	metery, cren wood Ce	natory or other metery	r place)	Facility		Balti	more, Mar	
Ba	Dermit. Departm Importe any inju		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate										
/Medica Examine	wate be executed //Medical Examiner and pural-transit the burial-transit	dicai Examiner	shock, or heart failure. List only of disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or b. Due to (or c.	as a conseque as a conseque as a conseque	ence of):	ma						Interval Between Onset and Death 3 mm/lbg
Box 6 auth certific auth certific for use as		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 ☐ Fetal of t at time of dea	death 3	Ectopic pregn					23d. Date of deliv Month	rery Day Year
rds, P.O.		Part II. Other significant conditions of	ontributing to deat	h but not resul	ting in the u	nderlying caus	e given in	Part I.		obacco u Yes 2		the cause of death?	
		Completed by								1 Yes	psy rmed? 2 No	prior to co	opsy findings available ompletion of cause of
f Vital	Physiclen: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Tyes 2 No	26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify)								fy)	
Division of	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 6 Could not be		(Month, Day Year) Injury Work? M 1 ☐ Yes 2 ☐ No						28d. Describe how injury occurred		
Divi	To the Hospitel or Att within 24 hours after d To the Funerel Direct completely filled in by 1		4 Homicide determined	building, etc. (Specify)				City or To	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical	29a. Certifier (Check only one) 29a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								to the cause(s)		
	To t Withi	Σ	29b. Signature and title of certifier	0			29c. License number 25 D28987			5/	29d. Date signed (Month, Day, Year) 5/27/05		
	3		30. Name and address of person who	ND S	GOI 4	DCH 1	CAUEN	BLI	D	BALTO, 1	MD	21239	
	Sta Registi		31. Date filed (Month, Day, Year) JUN 0 1 200	32. Reg	istrar's Signatu	Jre dos	Es.						

٠		-	For State Registrar		State of	Marylan	-	artment			and M	iental Hy	giene	200	-	18280
	•		Decedent's Name (First, I	Middle, Last)								2. Date of De	eath			3. Time of Death
	Physici /Medic		Mary Cat	nerine	Henry							Month 05-	Da	7-0	sar 5	10:499 M
	Examin		4a. Facility Name (If not inst	tution, give	street and numb	er)		4b. City,	Town, or	Location of	of Death			. County of		
0.7			Franklin Squ	iare,	Hospita	1 Cen	kr	If Under	Sed	2. Le If Under	24 Hrs	2 Data of Bi		Balt	mo	re
	Funeral Director		5. Social Security Number 215-03-4795	6. Se	M 217 F	Age (In yrs. 97		Months	Days	Hours	Min.	8. Date of Bi	196	7 M	ary)	ace (State or Foreign
			Usual Residence of Decede	nt									, , ,			
	show	_	10a. State 10b. Co	•		10c. Cit	y, Town or Lo								10	d. Inside City Limits
	the Marylan r 28e-f show rylithed at	Director	MD B	altimo	re		Baltin		0 - 1 -				10= 0	tizen of Wha	10000	1 ☐ Yes 2 No
	filed within 72 hours after death with the Maryland Hygiene. yther then "natural", or Items 23e or 28e-f show ent, the Medical Evaninar must be notified at		1315 Chesac	o Aven	iue A	pt. 22	0	10f. Zip 21	206				-	S.A.	it Count	ry :
	r dea	Funerai	11. Marital Status		12. Was Decede Armed Force	es?		Was Deced If Yes, spec	ent of His	spanic Ori n, Mexicar	gin? (Spe	ecify Yes or N Rican, etc.)	0-	14. Race - Black,	America White, e	
336	urs afte	by Fi	1 X Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Dive		1 Tyes 2 If Yes, Give Year or Date	No es:		1 🗆 Yes 2	No K	Specify:				Specify:	Wh	ite
2-0	72 hours "natural",	ted	15. Dec (Specify only)	edent's Edu	cation e completed)		(Give	dent's Usua kind of wor	k done d	urina mos	t of worki	ina	16b. K	and of Busin	ess/Ind	ustry
21215-0036	within and the "then "then "then "then "then "the the the the the the the the the the	Completed	Elementary/Secondary (0		College (1-4	or 5+)	life.	DO NOT us Homema	e retired)			9		Own Ho	ome	
9	filed v Hygie other I	e Co	17. Father's Name (First, Mi	ddle, Last)			l	TOMONIA		18. Mothe	or's Name	(First, Middle	L			
Maryland	s 1 and 2 should be filed within 72 h if Health and Mental Hygene. Item 27 is marked other then "natu other treumatic event, the Medical	To Be	William M. H	lenry						Mar	y J.	Snyde	r			
Jan	2 sho		19a. Informant's Name/Rela				1					Al Route Numb				
	1 and Health em 27	1	Mr. Thomas N 20a. Method of Disposition	1. Ewe	rs/Nepn	20b. F	lace of Dispo	sition (Nam	ne of			ltimor		ary1a1 ocation · Cit		
JOL.	80 = 5		1 Burial 2 Crema 4 Donation 5 Oth			ลเด เ	emetery, cre st Hol			'	5/31/	' 05				aryland
Baltimore,	permit. Pages 1 and 3 Department of Health Importent: If item 27 any injury or other tru once.		21. Signature of Funeral Se				n 2	2. Name an	d Addres	s of Facilit	y Lec	nard J Baltim	. Ru	ck, Ir	nc.	
			23a. Part1. Enter the disea shock, or heart failure	se, or compl	ications that cau	sed the deat								Tiul y	Laria	Approximate Interval Between
	Enysician	0	Immediate Cause (Final disease or condition	2.01 0.11, 0.	Pul	mona	ru	Fmh	nlie	n i						Onset and Death
	/Medical Examiner		resulting in death)		Due to (or	as a conseq	u of):	T	9	6.6. 6					7	
1	.5	e.	Sequentially list conditions, if any, loading to mine dialscause. Enter Underlying Cause (Disease or injury		Due 10 (or	ak a consec	uanga of):	rom	000	8/3						
1	and I-transit	Examiner	that initiated events	1	3											
50,	ate be executed physician and the burial-transii	i Ex	resulting in death) Last	1	Due to (or	as a conseq	uence of):									
8760,	ate hys the	dicai			J											
Вох 6	eath certifi attending I for use as	n/Me	IF FEMALE: 23b. Was decedent pregna	nt 2	3c. If yes, outco			7=						23d. Date o	f deliver	y
	ne death the atte thed for	Physician/Me	in the past 12 months' 1 ☐ Yes 2 🗷 No			h 2∏Feta nt at time of d m		□Ectopic pro☐ Other (sp						Month	(Day Year
P.0	that the de ed by the detached	Phy	9 Unknown Part II. Other significant co	nditions co			ulting in the r	ınderlyina cı	auco aiva	n in Part I		23e Did	tobacco	use contribu	te to the	e cause of death?
Records,	uires tha signed Id be de	Completed by	Congestive.	hear-	+ Failu	re	aking in the c	indonying or	auso givo	iriiri airi	•		Yes 2] Proba	
COL	w requir s been si should	olete	Viral D	neur	nonia							24a. Was		24b. Wei	e autop	sy findings available
Re	The lav	mo	VIII W	/CC_V	7011100							auto perf	opsy ormed? 2 25. No	dea	r to com th? Yes :	pletion of cause of
/ita	lcien: Th certificate rector, pag	Be	25. Was case referred to m	-							of Death	Check only	one)			
of \	Physical this call dire	은	1 ☐ Yes 2 No 27. Manner of Death		Hospital: 10 Inc		ER/Outpatie	_		4 🗀 NU		me 5 🗆 Res 28d. Describe			Specify,)
no	ding land h. After funer	tion	1 Natural 5 □ F	ending vestigation	28a. Date of (Month,	Day Year)	Injury	M Z	8c. Injury Work 1 🗀 Y	ai ? ′es 2.⊟		280. Describe	riow iriju	ry occurred		
Division of Vital	or Attendi after death. Director: A	fica	3 Suicide 6 C	ould not be etermined	28e. Place o	f Injury - At h	ome, farm, st	reet, factory			-				or Rural	Route Number,
Ö	tel or rs after el Dire	Certification:	4 Homicide		Duilding	, etc. (Specif	y) 					City or To	wn, State	ə <i>)</i> 		
	To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical			sicien: To the b ner: On the bas and manne	is of examina										
	To the complex	Σ	29b. Signature and title of d	ertifier 1/1/	18 7	Auch	na,		License	number	728	3	29d. Da	te signed (A	Aonth, D	Day, Year)
	5		30. Name and address of p		ompleted cause	of death (Iter	# 1 0	Print)	316	Tin	ve	- , n	10	21	23	7
	Sta Regist		31. Date filed (Month, Day,	Year) 1 201	32 Reg	gistrar's Signa	ature	artis)								

State Registrar

JUN 0 1 2005

31. Date filed (Month, Day, Year,

2. Registrar's Signature

30. Name and address of person who completed cluse of death (Item 23a) (Type, Print)

howele

111 Penn Street

Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Month Year **Physician** 2:43 A M 2005 Eva M. Johnson May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Charlestown Care Center Catonsville 8. Date of Birth (Month, Day, Year) June 22,1911 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 □ M 2 🗓 F 577-50-7088 Yrs. 93 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "nature!", or Items 23a or 28a-f show the Medical Exercites must be notified at 1 ☐ Yes 2 No Funeral Director Maryland Catonsville Baltimore 10g. Citizen of Whal Country? 10e, Street and Number 10f. Zip Code 717 Maiden Choice Lane St519 21228 U.S.A. 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: ģ 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Professor George Washington Univ. . Pages 1 and 2 should be filed w iment of Heath and Mental Hygie tent: if item 27 is marked other to jury or other treumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Josephine Vilkis August Magdurakas ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JoAnn D. Hixon 413 West Side Blvd. Catonsville, Maryland 21228 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory | 5-31-2005 | Beltsville, Maryland ^{22. Name and} Address of Facility
Witzke Funeral Home of Catonsville, Inc.
1630 Edmondson Ave Catonsville, Maryland 21228 21. Signature of Femal Survice Licensee 101290 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or rear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tomach Cancer 2015 **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): ending physician a use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? for 5 Other (specify) 4☐Pregnant al time of death ed by the a detached f P.O. 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes Æ No certificate Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director Be examiner Hospital: Other: 5 Residence 6 Other (Specify) 1 ☐ Yes 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA this After the 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medicel Exeminer: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 200 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) atunsy. Cordi de ane 31. Date filed (Month, Day, Year) 32. Registar's Signature State Registrar

			For State Registrar	State of I	Maryland		artment rtificate			and M		iene	005	18292
	- · ·		1. Decedent's Name (First, Middle, L	•							2. Date of Dea Month	th Day	Year_	3. Time of Death
	Physicia /Medic		Eileen, J	ay							05	23	05	1410 M
	Examin		4a. Facility Name (If not institution, gr	ve street and numb	er)				Location of	of Death			nty of Death	0
			Howard County Gen			4 to 2-44	CO/			24 Hrs	O Data of Right			
	Funeral			Sex 7. 1 ☐ M 2 🛣 F	Age (In yrs. last	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Oct. 15	Year)	Cour	lace (State or Foreign stry) Land
	Director		219-50-6047 Usual Residence of Decedent		00						UCL. 13	,1940	Mary	Tallu
	yland yland		10a. State 10b. County		10c. City, T	Town or Lo	ocation						1	Od. Inside City Limits
	e-fs	ctor	Maryland Howar	d	E11	icott	t City	7						1 ☐ Yes 2 🔁 No
	or 28	Jire	10e. Street and Number				10f. Zip	Code				0g. Citizen o	of What Cour	ntry?
	ath w	rai	4650 South Le					2104					S.A.	
	er de Itams	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decede Armed Force 1 Tes 2	es?	13.	Was Decede If Yes, speci	ent of Hi ify Cuba	ispanic Origin, Mexican	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		lace - Americ lack, White,	
36	irs aft	by F	3 Widowed 4 Divorced	If Yes, Give Year or Date			1 ☐ Yes 2	2 ⊠ No	Specify:			Spec	cify: Wh	ite
ò	d within 72 hours after death with the Maryland Jiene. Ir than "netural", or Itams 23e or 28e-1 show The Madical Examinat must be incillised at	ted	15. Decedent's 1		1	16a. Dece	dent's Usual	I Occupa	ation	a ad consider		16b. Kind of		
21	e. an "n	pie	(Specify only highest g Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT use	e retired	during mosi f)	LOI WOIKI	rig			
2	77 5 5 5	Completed		2+		At	strac	ter					Estate	2
nd	tal Hi	Be	17. Father's Name (First, Middle, Las	t)							(First, Middle,		ame)	
3	d 2 should be filed th and Mental Hyg 7 is marked othe traumatic avant,	P	Charles Kane	(Time Brint)		10b Mailie	an Addrage	/Stroot			s Wrigh al Route Numbe		m State Zin	Codo
Maryland 21215-0036	d 2 shoth and the and 7 is m		19a. Informant's Name/Relationship Rick Jay (Husba				South							MD 21043
	s 1 and of Healt itam 2 other		20a. Method of Disposition	nu)			osition (Nam matory or ot				Date	20c. Locatio		
DI DI	8 2 = 5		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		ale					5-30	-2005	Laural	Mary	land
Baltimore,	그 문 뿐 중		21. Signature of Funeral Service Lic		1						of Cat			
m	Depar Impo		hubile for	tales		16	30 Ed	lmon	dson_	Ave.	Catons	ville,	_Maryl	and 21228
			23a. Part1. Enter the disease, or co shock, or heart failure. List on			Do not ent	ter the mode	of dyin	g, such as	cardiac o	or respiratory arr	est,		Approximate Interval Between
2	Physician	i Tr	Immediate Cause (Final disease or condition	Acu	Te resp	orat	bry	2	stre	15 5	n drome	2		Onset and Death
	/Medical Examiner		resulting in death)		as a consequer	nce of):								0
		ē	Sequentially list conditions,	b. Emp	nyema	nos offe								10 days
	ted nsit		cause. Enter Underlying Cause (Disease or injury	_	LMONIG									
,	sician and burial-transit	Examin	that initiated events resulting in death) Last	C	as a consequer									
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be deteched for use as the burial-transit	icai		d										
68	rtifica ng ph as th	ed	IF FEMALE.											
Вох	leath certifica attending pl d for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco 1□Live birt	me of pregnanc h 2 Fetal de		☐Ectopic pre	egnancy	,				Date of delive	ery Day Year
	at the dea by the at tached fo	/slci	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnar 9□Unknow	nt at time of deat m	th 5 🗆	Other (spe	ecify)						Day Tour
P.0	that the		Part II, Other significant conditions	contributing to dea	th but not resulting	na in the u	nderiving ca	ause div	en in Part I		23e. Did to	bacco use co	ontribute to the	ne cause of death?
Records,	signe d be	d by	Anaemia				, ,				1 □ Y	es 2□No	3 Prob	ably 4 Unknown
Ö	v requir been si should	Completed									24a. Was a	an 24	b. Were auto	psy findings available
Re	The lavate has	duc									autop	med?	prior to co death?	mpletion of cause of 2□ No
Vital		0	25. Was case referred to medical						26. Place	of Death	1 Tes	24 No ne)	T Tes	2 NO
\leq	Physiclan: r this certificant all director,	To B	examiner? 1 ☐ Yes 2 Œ No	Hospital: 1 Minp	atient 2 EF	3/Outpatier	nt 3 DO	A Oth	er: 4□ Nu	rsing Ho	me 5 Resid	ence 6 🗆 C	Other (Specif	(y)
n of	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of (Month,	Injury 28 Day Year)	8b. Time o Injury		8c. Injun Wor			28d. Describe h	ow injury occ	curred	
Sio	an eatl or: he	cati	2 Accident investigat 3 Suicide 6 Could not	ho -			М		Yes 2		201 1			10-11
Division	ira ira	Certification;	4 Homicide determine	d 289. Place of	f Injury - At homo j, etc. <i>(Specify)</i>	e, farm, sti	reet, factory	, office			City or Tow	n, State)	mber or Aura	al Route Number,
	Hospital 4 hours a Funaral tely filled		29a. Certifier 1 Certifying	Physician: To the b	est of my knowle	edge, deat	h occurred a	at the tin	ne, date an	nd place,	and due to the o	ause(s) and	manner as s	tated.
	To the Hospital of within 24 hours af To the Funaral D completely filled in	edical		aminer: On the bas and manne	is of examination									
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier	6 0					e number			29d. Date sig		
			haver	hwad.			i	00	060	345	-	5/24	1105	te .
	01		30. Name and address of person wh		of death (Item 2	За) (Туре,	Print)	/		11 X	2111	1,		
				tue xant	Parker!	y	C014	mi	na	MD.	2104	4		
	.⊫ Sta Registi		31. Date filed (Month, Day, Year)	0 1 2005	gistrads Signatur	A	Ana	All I						
	3.0		אוטוני	V 1 4000	TIB MEDERA	Fed?	100	-						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene
1- State Amend #5 Per FH G863 1/16/07 Health and Mental Hygiene
Red. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10:45 Nathaniel Johnson AM May 27, 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3308 Essex Road n/a Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Sec**21730** ber 8. Date of Birth (Month, Day, Year) 6 - 2 - 1 9 4 4 6. Sex 1 M 2 ☐ F Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 228-50-7230 Director 60 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath; and Mental Hygiene. Int: If item 27 is marked other than "natural", or itams 23a or 28a-f show 10c City Town or Location 10d. Inside City Limits 10a State 10h County ral', or itams 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 🎗 💢 No Director Baltimore n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3308 Essex Road 21207 USA Completed by Funeral 12. Was Decedent Ever in U.S. Amed Forces?
1 (A) Yes 2 □ No
If Yes, Give 1964 - 68 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Mount Moriah College (1-4or 5+) 5+ Elementary/Secondary (0-12) Pastor Missionary Baptist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James Arthur Johnson Sarah Frances Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3308 Essex Road, Baltinore, Vid 21207
Disposition (Name of Date 20c. Location - City or Town, State Lillie V, Johnson/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) ayer partment of Important: If ite, any injury or oth-once. 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 6 - 4 - 05Woodlawn, Md *4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie F/H of Balto. Co 21. Signature / Furreral Service Licensee 9200 Liberty Rd. Randallstown, MD 21133 an Enfer the Thease, or implications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myeloma Multiple Physician 4 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an certificate has autopsy performed 1 ☐ Yes 2BNo Hospital or Attending Physician: Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 🗷 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🗷 No this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 XNatural death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours a 1 decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical To the within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number davan D 0059027 05-31-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yarlagadda MD, ONCOLOGY, ION- GREENE ST, Room 2 C/27 Lavanya 32. egistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene

			Cer	tificate of Death		g. No. 🤈 🔿 💍 🗁	
			1. Decedent's Name (First, Middle, Lest)		2. Date of Death Month	Dev Year	. Time of Death
	Physici /Medio		ANNA E. JONES		May	28, 2005	1:58 AM
الممر	Examir		4a Fecility Name (If not institution, give street end number)	4b. City, Town, or Le		4c. County of Death	
			Edward W. McCready Memorial Hospital	Crisf:	leld	Somer	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 1	Months Days Hours Min.	8. Date of Birth (Month, Day, APTIL 2	Year) 916 Country)	e (State or Foreign
	Director	ı	220-66-3229 Usual Residence of Decedent			Maryla	na
	ylend Mor		10a. Stete 10b. County 10c. City, Town or Lo	cation			Inside City Limits
	Mar a-f st	ţċ	Maryland Somerset	Ewell			1 ☐ Yes 2X No
	き 28 8 28	Director	10e. Street end Number	10f. Zip Code	10	g. Citizen of What Country?	?
	23a	la	20797 Caleb Jones Road	21824		USA	1-30-
	tems tems	nue	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces?	Vas Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - American I Black, White, etc.	
20	s afte	Ϋ́F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 7 Sar Vear or Dates:	I□Yes 2∑XNo <i>Specify:</i>		Specify: Whit	.e
8	filed within 72 hours after death with the Marylend Hygiene. ther than "natural", or frems 23s or 25s-f show ent, the Medical Examiner must be notilized at	Be Completed by Funeral	15 Decedent's Education 16s Dece	lent's Usual Occupation		16b. Kind of Business/Indust	try
21215-0020	nin 72	plet	(Specify only highest grade completed) (Give life. I	kind of work done during most of work DO NOT use retired)	ing		
7	d with	E	6	Homemaker		Own H	lome
2	al Hy	Be C	17. Father's Neme (First, Middle, Last)	18. Mother's Nam	e (First, Middle, N	faiden Sumame)	
<u>yla</u>	Ment Ment arked	To	Edgar Brimer	Gertie			
Maryland	2 sh		1.2	ng Address (Street and Number or Ru			
ď	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show appriant: if item 27 is marked other than "natural", or items 23a or 28a-f show applying yor other traumatic event, the Medical Examinat must be notified at once.			7 Center Street -		20c. Location - City or Town,	
Baltimore,	it of h		1 Burial 2 Cremation 3 Chemoval from State	sition (Name of netory or other place)			
<u>=</u>	it. Pa ntmer rtant: njury			urch Cemetery 6, Name and Address of Fecility	/1/05 1	Ewell, Maryla	ina
Ва	Dependent of the population of		Mary Keth Bladshaw-Reutt	Bradshaw & Sons :			•
			Mary Beth Bradshaw-Pruitt 23a. Part 1. Enter the disease, or complications that caused the death. Do not ent	306 W. Main Stree	et - Cris	sfield, Maryl	and 21817
4			shock, or heart failure. List only one cause on each line.	or the mode of dying, each as earen	or roopilatory and	Or	pproximate terval Between nset and Death
	Physician /Medical		Immediate Cause (Final	0.18		mo	agels
	Examiner		disease or condition resulting in death) Due to (or as a consec	>> >>			
		ē	= ENDOMETRIA			Two yes	me
Ŋ	tificate be exec ted og physician end es the buriel-transit	edical Examiner	0.				
Ö,	e exe ian er uriel-t	EX	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of the				
68760,	the b	dica	that initiated events resulting in death) Last Due to (or as e consequence)	uence of):			
9 ×			d				
Box	v requires that the death cer been signed by the ettendir should be deteched for use	Physician/M			ant Bids		2 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4
P. 0.	the de	ıysi	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		bacco use contribute to the	oly 4 □ Unknown
	that ned by dete	by Pt				, 1210 to 100	.,
rds,	requires seen sign				24a. Was a		autopsy findings ble prior to
Record	law rec les bee e 2 shor	olete			poriori	compl of dea	letion of cause
	0 - 5	Completed			1ZY	99 2L4No 1 Y	es 2 No
	Iclan: The certificete rector, peg	BeC	25. Was case referred to medical	26. Place of Dea	th (Check only on	e)	
>	S S	70 E	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatier			ence 6 Other (Specify)	
	ng Ph ter th meral		27. Manner of Death 1 ☑Natural 5 ☐ Pending 28e. Dete of Injury (Month, Dey Year) 1 ☑Natural	Work?	28d. Describe ho	ow injury occurred	
Sio	Attending ir death. actor: After by the fune	catl	2 Accident investigation	M 1 Yes 2 No	004 1	reet and Number or Rural R	lauta klumbar
-	or Att	Certification:	4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide	eet, factory, oπice	City or Towr	n, State)	loute Number,
	To the Hospital or Attending Phy within 24 hours effer death. To the Funeral Director: Affer thi completely filled in by the funeral	₹ Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place	, and due to the ca	ause(s) and manner as state	ed.
	24 hg Fun etely	edical	(Check only one) Check only one) Check only one) Check only one)	vestigation, in my opinion, death occu	rred at the time, d	ate and place, and due to th	e cause(s)
	Го th i Mithin Го the	M	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Month, Day	y, Year)
	. ,,-0		Meuro	1)3981	3	5/31/20	200
	/		30. Name and eddress of person who completed cause of deeth (Item 23a) (Type,	D 3981	7 -	- 00	- 10-13
_			M. ATKINS MD 201	Usle Keylow 1	3 CRis	stold my	2181)
		ate	31. Dete filed (Month, Dey, Year) 32. Begistrar's Signature				
	Regist	rar	JUN 0 1 2005 Abanco & So				

DHMH 16 Rev 6/95

			State	partment of Health and Mertificate of Death		2000	10000
7			Registrar 1. Decedent's Name (First, Middle, Last)	Stillicate of Death	2. Date of Death	. No: ()	3. Time of Death
9	Physicia		WILMER TRACEY JONES, JR.		Month	Day Year 2005	12:00 P.M
0	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
3/			GILCHRIST CENTER	TOWSON If Under 1 Year If Under 24 Hrs.	D. Date of Dight	BALTIMORE	
	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Months Days Hours Min.	8. Date of Birth (Month, Day, You 1/11/192	ear) Coun	lace (State or Foreign try) LAND
h			Usual Residence of Decedent				Od. Inside City Limits
0	show ed et	or	10a. State 10b. County 10c. City, Town or MD BALTIMORE PA	ARKVILLE		'	1 Yes 2 XNo
1	death with the Maryland ms 23e or 28e-f show	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Coun	try?
4	h with	al Di	8547 KINGS RIDGE ROAD	21234		USA	
l.	r deal	Funeral		 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
.vq	36 irs afte	by F	1 ☐ Never Married 2 ☐ Married 1 至 Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WWII	1 ☐ Yes 2 🖾 No Specify:		Specify: WHI	TE
	21215-0036 bd within 72 hours all gjene. er than "naturel", or than "naturel", or the Medical Exam.		(Specify only highest grade completed) (G.	cedent's Usual Occupation ive kind of work done during most of work	sina 16	b. Kind of Business/Ind	Justry
2	Aithin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	a. DO NOT use retired)		JBLIC UTILI	ケイぞく
3	d 2. filled v Hygie other t		2 YEARS I	ESTIMATOR 18. Mother's Nam	e (First, Middle, Ma		1100
11	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mandlal Hygiens. Importent: If item 27 is marked other than "naturel," or Items 23e or 28e-1 show enty injury or other treumatic event, the Medical Examinational Demotral on once.	To Be	WILMER TRACEY JONES, SR.	ELIZAE	ETH ELSIE	E MCCLAIN	
3	lary 2 shou and h ls ma euma			ailing Address (Street and Number or Rur		_	1
	e, N 1 and 1 and 1 ealth 3 m 27 ther tr			47 KINGS RIDGE ROAD		DRE MD 21 Ic. Location - City or To	234 own, State
M)	nor ages ant of I		1X Burial 2 Cremation 3 Removal from State DULANEY	VALLEY MEM. 5/31	/2005	COCKEYSVILL	E, MD
ONES	Baltimore, bermit. Pages 1 ar Department of Hea mportent: If item any injury or othe		21. Signature if Funeral Service Licensee	ARDENS 22. Name and Address of Facility TH	E JOHNSON	I FUNERAL H	OME, P.A.
7	Dall Depar Impor eny in		Heather P. Harp	8521 LOCH RAVEN BL			
,	1.0		23a. Fant. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause or each line.				Approximate Interval Between Onset and Death
	Physician /Medical		resulting in death)	e vascular	Chrea	se 1	reers
_	Examiner		Due to (or as a consequence off:				V
	₽ ≃	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	60, be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events c				
	\$8760, icate be ex physician s the burian	dical E					
	687 tificate ng phys as the	fedic	0.				
	O. Box 6: ne death certific the attending p	Physician/Me		3 Ectopic pregnancy		23d. Date of delive Month	ery Day Year
	P.O. It	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)			
	cords, P.C. w requires that the s been signed by the should be detach		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
	ords aquire en sig	ted t	Dispoetes		1 Yes	2 □ No 3 □ Prob	ably 4 Unknown
	lecc lawra nas be	Completed by	(Shemic Cardianyopathy		24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
	Vital Rec nician: The lav certificate has rector, page 2				performe	PNo 1 ☐ Yes	2 🗆 No
	f Vita ysician: is certific director,	o Be	25. Was case referred to medical examiner? 1	Other	th (Check only one) ome 5 Aesiden	ce 6 ther (Specif	nospia
	ng Phy ter this	-	27. Manner of Death 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	e of 28c. Injury at	28d. Describe how	-	
	Sion tendir seath. tor: Al	catle	2 Accident investigation	M 1 Tyes 2 No	28f Location (Stre	et and Number or Rura	al Route Number
	Division of Vital Records, to Attending Physician: The law requires that after death. Director: After this certificate has been signed in by the funeral director, page 2 should be	Certification:	4 Homicide determined determined determined building, etc. (Specify)	street, factory, office	City or Town,		Trioble resinour,
	Division of Vital Records, P.O. Box 6 To the Hospitel or Attending Physician: The law requires that the death certifit within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	edical C	29a. Certifier (Check only Medical Examiner: On the basis of examination and/o				
	the H hin 24 the F mplete	Medi	and manner stated. 29b. Sonature and fittle of certifier	29c. License number		1. Date signed (Month,	
	To with					_	
	ادا سو		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe. Print) Charles St Br	14 -		
	31		AMON Charles MD 6601 N.	Charles It Br	more &	WILILOG	/
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUN 0 1 2005 32. Registrar's Signature	carles			

			1 State	•	artment of Health and N		ene 1. No.2 0 0 5	19206
			Registrar 1. Decedent's Name (First, Middle, Last)		Timodio or Dodin	2. Date of Death		3. Time of Death
	Physicia		Marvin Stewart	Kohler, Jr.		Month May 31,	Day Year 2005	12:05 pm
	/Medic Examin		4a. Facility Name (If not institution, give street and nut		4b. City, Town, or Location of Death	1227	4c. County of Deatl	
			Ivy Hall Geriatric Cente	er	Middle River		Baltimore	2
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,)	rear) Co	nplace (State or Foreign untry)
	Director		216–72–7447 Usual Residence of Decedent	47 Yrs.		1/30/19	58 <u>Mar</u>	yland
	land ow		10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	Mary I sh	to	Maryland Baltimore	Middle Ri	ver			1 ∐ Yes 2 🛣 No
	death with the Maryland ms 23a or 28a-f show rmust be notified at	Director	10e. Street and Number	THUGE IN	10f. Zip Code	10	g. Citizen of What Co	untry?
	th wit		10137 Bird River Road		21220	U	. S. A.	
	ams	Funeral	Armed Fo	edent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, White	
9	hours after tural', or Ita al Examina	by Ft	1 ☐ Never Married 2 【X Married 1 ☐ Yes If Yes, Gir	2 X No	1 ☐ Yes 2 XNo Specify:		Specify:	
Ş	filed within 72 hours after death with the Marylar I Hygiene. othar than "netural", or Itams 23e or 28e-f show rent. The Medical Examinar must be notified at		3 Widowed 4 Divorced Year or D		dent's Usual Occupation	14	3b. Kind of Business/l	White
ဂ်	in 72 "nal	Completed	(Specify only highest grade completed)	(Give	kind of work done during most of work DO NOT use retired)	ing	DD. KING OF BUSINESSA	ndustry
<u> </u>	within iene.	m o	Elementary/Secondary (0-12) College (Ground	dsman		Apartment	Complex
0	be filed tal Hyg d othar avent.	0	17. Father's Name (First, Middle, Last)	TOLOGI.		e (First, Middle, Ma	_	COMPLOIL
a	uld be fenta rkad tic av	To B	Marvin Stewart Kohle	er. Sr.	Nancy	Jane H	essie	
ary	should be should	٦.	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Rui			ip Code)
Ξ	and 2 salth n 27 I		Debra Ann Kohler (Wife			dle Rive	r, Marylar	nd 21220
ore	ges 1 and of Healt If item 2		20a. Method of Disposition 1 □ Burial 2 🎖 Cremation 3 □ Removal from	20b. Place of Dispo cemetery, crea	matory or other place)		oc. Location - City or	Town, State
Ĕ	Page ment o ant: If ury or		'4 □ Donation 5 □ Other (Specify)		Crematory 200!	5 В	altimore,	Maryland
žait	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Licensee	B	2. Name and Address of Facility ruzdzinski Funera	l Home PA		
_	<u>20599</u>		Michael C. Zaffin	5. 1	<u>407 Old Eastern Av</u>	venue Es	sex, Maryl	
			23a. Part1. Enter the disease, or complications that of shock, or heart failure. List only one cause on e		er the mode of dying, such as cardiac	or respiratory arres	it.	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	led (and	econsola/4	. 4		Orisot and Boatin
	/Medical Examiner		Due to	or as a consequence of):	The day	1		
		7	Sequentially list conditions, if any, leading to immediate	or as a consequence of):	aja) cak	are	\sim	
	ted nsit	Examiner	Cause (Disease or injury	in ofta	untia De Dun	val.	hier	
	be executed ician and burial-transit	xaı	that initiated events resulting in death) Last Due to	or as a consequence of):	0111	1.00.9	grace	
0/g								
000	certificate iding phys	ledical					T	
X Q Q		Physician/M	23b. was decedent pregnant	come of pregnancy irth 2 Fetal death 3	Ectopic pregnancy		23d. Date of deli	*
מ	deat ne atte ad for	sicia	1 Yes 2 No	ant at time of death 5	Other (specify)		Month	Day Year
τ. Ο	that the death ed by the atter detached for i	Phy	9 🗆 Unknown				1	
'n	Se Libe	by	Part II. Dther significant conditions contributing to d	eath but not resulting in the u	nderlying cause given in Part I.		cco use contribute to	
ecords	inpen s	ted				1 Yes	2 □ No 3 □ Pro	obably 4 □Unknown
	a law a	Completed				24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
	The I	Cor				performe 1 ☐ Yes 2	d? death? XNo 1 ☐ Yes	2 No
Vitai K	Physician: The law this certificate has trail director, page 2 s	Be	25. Was case referred to medical examiner? Hospital:		Othor	th (Check only one)		
ō	a this	To :	1 ☐ Yes 2 🛣 No 1 ☐ 1 ☐ 27. Manner of Death 28a. Date	npatient 2 ER/Outpatier of Injury 28b. Time o	IL 3 DOA 4 THUISING H	ome 5 Residen 28d. Describe how	ce 6 Other (Spec	ify)
	ding Ph h. After th funeral	ertification:	1 ☑Natural 5 ☐ Pending (Mon 2 ☐ Accident investigation	th, Day Year) Injury	f 28c. Injury at Work? M 1 Yes 2 No		,,	
DIVISION	deat deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not be 28e. Place	of Injury - At home, farm, str			et and Number or Ru	ral Route Number,
	al or Attending F s after death. Il Diractor: After id in by the funer	erti	4 Homicide determined buildi	ng, etc. (Specify)		City or Town,	State)	
	spita hours inera y fille	alc	29a. Certifier 1 Certifying Physician: To the	best of my knowledge, deat	h occurred at the time, date and place,	and due to the cau	se(s) and manner as	stated.
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical		asis of examination and/or in ner stated.	vestigation, in my opinion, death occur			
	To t To t	3/	29b. Signature and title of certifier	n. ~ / ,	29c. License number	L L	d. Date signed (Month	, Day, Year)
	///	8	Saly ((M	our, M.	D38033	0	6/01/6	
1	10	~	11- ~ 2010/	e of death (Item 23a) (Type,	D38033	40 =	2,220	0
Į		1	31. Date filed (Month, Day, Year) 11. 0 1 32 F	Typung	100 /31001.1	11 0	100	7
	Sta Registr		JUN 0 1 200	gistial spolyriature	" pour			
		V		1.	•			

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 26, 2005 Timothu Patrick Kellu 4:45 P May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center Towson 8. Date of Birth (Month, Day, Year) Fo.b. 17,1950 If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**∑**M 2□F Mary Land 55 216-54-7471 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28e-f show 1 ☐ Yes 2 No treumatic event, it e Medical Examiner must be notified Director Maryland Baltimore Baltimore 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21236 9507 Hallhurst Road U.S.A. or Items 23a Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 XYes 2□ Victnam
Year or Dates: Fha 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Iter any injury or other treumatic event, Ite Medical Examiner. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: δ 3 ☐ Widowed 4 ☐ Divorced Era Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Hospital Management 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lois Maru Rohr Kellu John Omer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9507 Hallhurst Road, Baltimore, MD 21236 Mrs. Charlene Kelly (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Parkwood Cemetery 5/31/2005 Baltimore. Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Fun 9705 Belair Rd., Baltimore, MD 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner myoc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit ner COA Due to (or as a consequence of): P.O. Box 68760. the attending physician Physiclan/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No o the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27, Manner of Death 28b. Time of 28c. Injury at Work? Certification: After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of pertifier MA727,2005 , and N. Chales St. Halts my 20x completed cause of de 1 em 23a) (Type, Print) 30. Name and address of person BMC 5 Registrar's Signature 31. Date filed (Month, Day, Year) 32. State JUN 0 1

DHMH 17 Rev 1/2001

Registrar

2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** MAY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MORE Noi: Du If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Days Months 1□M 200 F Hours MAR Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location other traumatic evant, the Medical Examiner must be nutified at 1 Yes 2 No Completed by Funeral Director MORE ALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 3838 121 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: 3 X Widowed 4 ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental F OST ranc ပ 19b. Mailing Address (Street and Number o Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health a ant: If itam 27 is 525 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date_ 20c. Location - City or Town, Slate permit. Pages Department of Important: If It any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of 21. Signature of Funeral Service Ligenses TIMONIUM MOZIO RD. ITE ACCEULATION WATER AND LEX ACRES KAINHTION 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on lone cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Breast **Physician** uncer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisause of Life) that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2[] No 1 🗆 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 2**V)** No Certification; To 1 🗌 Yes 2 ER/Outpatient 3 DOA 6 Dother (Specify) 1 Inpatient this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death or Attanding 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Diractor; 28l. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) filled in by 4 | Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

AZMAIER

0

d

و

State

Registrar

Medicai

TAMON Charles,

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

(Check only one)

29c. License number

29d. Date signed (Month, Day, Year) 27 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St

mo 6601 N Charles

32. Registrar's Signature

within 2 To tha

0

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician lane 2:30P 24 2005 May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Columbia Asleighs Place If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. Months Hours 1 ☐ M 2 ☑ F Yrs 90 488-10-1366 15,1914 Missouri Director Nov. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show rei', or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 1 No Directo Maryland Howard Columbia 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 4914 Canvasback Court 21045 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Iten any injury or other traumatic event. If a Medical Fran 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ₩Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Walsh Mary Kelly 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Son) 8073 Hillrise Court Elkridge, Maryland 21075 Robert Kohler 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Balto/Wash Crematory 5-27-2005 Laurel, Maryland 4 Donation 21. Signature Fundal Service Lice 22. Name and Address of Facility
Witzke Funeral Homes, Inc.
5555 Twin Knolls Road Columbia, Maryland 21045 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-tran that initiated events and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 Yo
9 Unknown Month Day Year 5 Other (specify) should be detached the signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. decubitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably Multiple 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform certificate 1 Yes hyperte 2 25. Wa case referred to medical examiner? Dulmonaru or Attending Physician: 26. Place of Death (Check only one) 43515/61 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 🗌 Nursing Home 6 ther (Specify) 5 Residence this 144/21 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) Injury 5 Pending 1 Natural 2 Accident ours after death. neral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide To the Hospitel within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier completely 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) oesler Rd Glen Burnie, MD 21060 D Etosha 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

EVANUS KING Baltimore, Maryland 21215-0036

			Please	Type or Print in Black II		•	
			1 - For State Registrar	•	partment of Health and Me ertificate of Death		
			Decedent's Name (First, Middle, La.			2. Date of Death	3. Time of Death
	Physici /Medic		EVANUS L	KING		Month OS	25 2005 10.30 A M
	Examin	er	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death
b	Funeral	-	GODD SAMAR 5. Social Security Number 6. S) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)
	Director		44-18-9044	□ M 2 PF 40 Yrs.	Months Days Hours Min.	AUS. 29,	1944 MARYLAND
	yland Iow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or I	ocation		10d. Inside City Limits
	e Mar	ctor	MP, NA	BAH	IMORE_		1 ₽Yes 2 □ No
	with th	Dire	10e. Street and Number	A. F	10f. Zip Code	10g.	Citizen of What Country?
	leath v	erai	11. Marital Status	12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Spec	cify Yes or No-	14. Race - American Indian,
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23a or 28e-1 show any injury or other treumatic event, If a Modical Examiner must be notified at once.	Completed by Funeral Director	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	. Was Decedent of Hispánic Origin? (Specify Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, White, etc. Specify: Black
5-0	72 ho 'natur	eted	15. Decedent's Ed (Specify only highest gra	de completed) (Giv	edent's Usual Occupation re kind of work done during most of workin	16b	. Kind of Business/Industry
21215-0036	filed within Hygiene. ther then "	ldmc	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOI use retired)		Flom5
	e filed with Il Hygiene. other ther vent, Ire I	Be Co	17. Father's Name (First, Middle, Last)	1 1 1	18. Mother's Name	(First, Middle, Maid	den Sumame)
ylar	2 should be filed withir and Mental Hygiene. is marked other then eumatic event, It e M	To	THOMAS KIN	16	JOAN	7/1/3/10	Wh/
Maryland	d 2 sh th and 17 is m treum		19a. Informant's Name/Relationship	Type, Print) 19b. Mai	ling Address (Street and Number or Rural	Route Number, Ci	ity or Town, State, Zip Code)
	es 1 and of Health fitem 27 r other tr		20a. Method of Disposition	20b. Place of Disp	position (Name of Diematory or other place),	ate 200	Location - City or Town, State
imo	Pages nent of I ant: If its ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif	Hemoval from State	O Crematory 5-24.	05 6	Town 1/6 MM
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr once.		21. Signature of Funeral Service Liber	isee	22. Valmerand Addres 40 Transitive 11 Full	MARO (10	ME PA
	405 40		23a. Party. Enter the disease, or com	plications that caused the death. Do not e	nter the mode of dving, such as cardiac or	respiratory arrest	Approximate
10	Priysician		shock, or heart failure. List only Immediate Cause (Final diseas - r condition	one cause on each line.		respiratory all sen	Interval Between Onset and Death
7	/Medical		resulting in death)	aSEPSIS Due to (or as a consequence of):			
g	Examiner	L	Sequentially list conditions, if any, leading to immediate	b. C. DIFF	ICILE COLITIS		
T	ted	Examiner	Cause (Disease or injury	Due to (or as a consequence of):	YLEMIA		
V	executed in and ial-transit	Exar	that initiated events resulting in death) Last	Due to (or as a consequence of):			
9289	ate be nysicia he bur	icai		d			
x 68	eath certificate be attending physicia for use as the bur	/Med	IF FEMALE:	23c. If yes, outcome of pregnancy			
Box	O O	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
P.0	at the de I by the a stached	Phys	9 🗆 Unknown	9□ Unknown			
	ires tha signed I d be det	by	Part II. Other significant conditions of	ontributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the cause of death? 2 ☑ 10 3 ☐ Probably 4 ☐ Unknown
cor	w requir been si should	letec		ATITIS B		24a. Was an	24b. Were autopsy findings available
of Vital Records,	2 5 0	Completed		ATITIS C		autopsy performed 1 Yes 2 P	prior to completion of cause of death?
/ital		BeC	25. Was case referred to medical examiner?	7. (((1))	26. Place of Death		140 15165 25140
of V		ပို	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatie	The second secon		e 6 ☐Other (Specify)
	fter	tion	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury 28b. Time (Month, Day Year) Injury		8d. Describe how i	njury occurred
Division	Hospitel or Attending 24 hours after death. Funerel Director: After tely filled in by the fune	Certification:	3 Suicide 6 Could not be determined		street, factory, office 2	8f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edicai C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of my knowledge, dea niner: On the basis of examination and/or i and manner stated.	ath occurred at the time, date and place, a investigation, in my opinion, death occurre	nd due to the cause d at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)
			Nehawto	, M.D.	RES-000	(05-25-2005

State Registrar , GOOD SAMARITAN HOSPITAL , LOCHRAVEN BOLLEVARD - BALTIMORE 21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

CHAWLA

31. Date filed (Month, Dây, Year) 32. Re

JUN 0 1 2005

NEENA

Messler SAMes

			_ For	Please	Type or Prin				k. Ensure . Health and	•		•	
			1 - State Registrer				Cei	tificate o	f Death		Reg. No	2005	18301
	Physici	an	_	e (First, Middle, La	,					2. Date of D Month	eath Da	y Year	3. Time of Death
	/Medic	al	James	M 1 1 1	Kessle	er ——		4. 05 -		5	38	0 0	6:30 PM
	Examin	er			e street and number)				or Location of Dea	ith		County of Death	
	Funeral		5. Social Security N		ex 7. Ag		last birthday)	If Under 1 Year	r If Under 24 Hr	s. 8. Date of Bi	rth	9 Birth	place (State or Foreign intry)
	Director		226-32-4	315	X M 2□F		76 Yrs.	Months Day	s Hours Mir	November	30,1	928 V	A.
	and *		Usual Residence o 10a. State	f Decedent 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Marylt f sho	ō	MD.	Baltimo	re			le Rive	c				1 ☐ Yes 2 💆 No
	ith the Marylar or 28a-f show or notiffed at	Director	10e. Street and Nu	mber				10f. Zip Code			10g. Ci	tizen of What Cou	intry?
	th with		601 Sopw.	ith Drive	Apt E			212	220			JSA	
	r dea	Funeral	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U	.S. 13. \	Vas Decedent of f Yes, specify Cu	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or N	0-	14. Race - Ameri Black, White	
20	s afte	by Fu	1 ☐ Never Marr 3 🛣 Widowed	ied 2 Married	1 □Yes 2 📉 If Yes, Give Year or Dates:	No	1	I⊡Yes 2X N		,		Cit	nite
2-003p	72 hours after death with the Maryland natural; or Items 23a or 28a-f show Jisal Exarch at Irousi Le molificol al			15. Decedent's Ed	ducation		16a. Deced	lent's Usual Occ	upation		16b. K	(ind of Business/Ir	
2	within 72 iene. than "nu	Completed	(Spec	ondary (0-12)	ide completed) College (1-4or 5	5+)	(Give	kind of work don OO NOT use retii	e during most of w	orking			,
N	filed with Hygiene. other than ant, Ire	Соп	10 years				Ma	intenano				neral Mot	ors
	be fill d oth evan	Be		(First, Middle, Last)	_					ame (First, Middle	e, Maider	n Sumame)	
2	of 2 should be filed within 72 hours after death with the Maryla it and Manal Hygiens it and marked other than "natural", or Items 23a or 28e-f show traumatic event, It a Medical Exactinatinating and	은		ames Kess			10b Mailin	a Addrona (Ctro	Lillie		os Citu	or Town State 7	o Co dol
<u>8</u>	l and 2 s Health an Im 27 is r her traur		Kenneth 1		sor	า			« Avenue,		-		p Code)
ก์	+ 4 4		20a. Method of Dis			20b. F	Place of Dispo	sition (Name of natory or other p		Date		ocation - City or T	own, State
Ē	Pages nent of int: If it		Magazial 2 1	☐ Cremation 3 ☐ 5 ☐ Other (Specify	Removal from State y)		•	emorial		3,2005	Bel	L-Air, MI) .
baitimor	permit. Pages Department of Important: If it any injury or c		21. Signature of F	neral Service Licer	nsee		22	. Name and Add	ress of Facility	Homo Of	Duna	Jalle D A	
D	40 5 9 9		ytu	5 ml	plications that caused				Funeral Lers Poin			falk, Md.	21222
	Physician /Medical Examiner	ıer	Immediate Cause disease or condition resulting in death) Sequentially list confirming to in	(Final on final on fi	a. Methic. Due to (or as	a conseq		ent Ste	phyloco	cc45 Qui	243	Poeumen	Interval Between Onset and Death
	executed in and ial-transit	Examiner	cause. Enter Under Cause (Disease or that initiated events	injurý s	С.								
Ġ,	be executed cian and burial-transit	Ex	resulting in death)	Last	Due to (or as	a conseq	uence of):						
00/00	cate b	dlca			d								
O. DOX 0	w requires that the death certificate be been signed by the attending physicial should be detached for use as the bur	Physician/Medic	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2(9 Unknown	months?	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Feta	tdeath 3□	Ectopic pregnan	cy			23d. Date of deliv Month	ery Day Year
cords, P	requires that the been signed by th hould be detache	ρ	Part II. Other signif	ficant conditions of	ontributing to death b	out not res	ulting in the ur	nderlying cause o	given in Part I.		/		the cause of death?
ב ב	elay has je 2	Completed	Cardio	my o pat	by mult	i. Ve	.55el	CAD		24a. Was auto perf 1 Yes		prior to co death?	opsy findings available ompletion of cause of
VII di	sician: Th certificate rector, pag	Bec	25. Was case refer examiner?	red to medical						eath (Check only			
5	Physician: this certific ral director,	ပ	1 ☐ Yes 2		Hospital: 1 Inpatie		ER/Outpatien	1 3 DOA		-		6 Other (Special	fy)
	ding F	tlon:	27. Manner of Deat	5 Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	W	ury at ork? □Yes 2□No	28d. Describe	how inju	ry occurred	
DIVISION	il or Attendi after death. Diractor: A d in by the fu	flcat	2 Accident 3 Suicide	investigation 6 Could not be	B One Diese of lei	urv - At ho	ome, farm, str			28f. Location	Street ar	nd Number or Run	al Route Number.
	after after Dira d in b	Certification:	4 - Homicide	determined	building, et	c. (Specif	y)	, radio, y, oillo	-	City or To			
	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier (Check only one)	12 Certifying Ph 2 Medical Exam	ysician: To the best niner: On the basis o and manner sta	t examina	wledge, death tion and/or inv	occurred at the restigation, in my	time, date and place opinion, death occ	e, and due to the curred at the time,	cause(s date an) and manner as s d place, and due t	stated. o the cause(s)
	To the Comp	Me	29b. Signature and	title of certifier	n n		. 5	29c. Lice	nse number			ite signed (Month,	Day, Year)
-		/	The	elito Li	repoler	9 1	10	R	25000		5/	28/05	
C	1				completed cause of d			,					
			31. Date filed (Mon	alem Pre	etom 900	00 Fr	anklin :	Square Dr	ive Baltir	noie, Mi	2	1237	
	Sta Registr	191	JU	N 0 1 2005	Reache	A.	Local	es a					

DHMH 17 Rev 1/2001

		1 - For State Registrar	State	of Marylar		artmen rtificate				F	Reg. No.		18302
Physic	ian	Decedent's Name (First, Middle								2. Date of Dea Month	ath AY 25,	⊃Y99%=	3. Time of Death 12:45A M
/Med Exami	ical	4a. Facility Name (If not institution Saint Jose;	ELMA SCHMI n, give street and no oh Medic	ımber)		4b. City,	Town, or	Location	of Death				imore
Funera Director		5. Social Security Number 214–38–6806	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. 96		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Sept.3	/, Year)		lace (State or Foreign try)
9		Usual Residence of Decedent 10a. State 10b. County		10c Ci	ty, Town or Le	ocation				Depers	0,1700		0d. Inside City Limits
Maryla f shor	ğ		Ltimore		Cowson	Joacion							1 ☐ Yes 🏋 XNo
deeth with the Maryland rme 23a or 28a-f show rmat be notified at	Funeral Director	10e. Street and Number	LLIMOTE		LOWSOII	10f. Zip	Code	_	-		10g. Citizen of	What Coun	itry?
eth will	la l	800 Southerly					2128				US		
ter de	une	11. Marital Status 1 ☐ Never Married 2 ☐ Mar	Armed F	edent Ever in U orces? 2 X No	J.S. 13.	Was Deced If Yes, spec	tent of Hi offy Cuba	ispanic Ori n, Mexicar	igin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)	14. Rad Bla	ce - Americ ck, White,	
d Z 1 Z 15-0050 filed within 72 hours efter dee Hyglene. ther then "netural, or fleme ont, Its Mudical Examination	þ	3X Widowed 4 □ Divorced	If Yes G	ive		1 ☐ Yes	2 X No	Specify:			Specif	y: wh	ite
72 hc	Completed	15. Deceder (Specify only highe	it's Education st grade completed)	16a. Dece (Give	dent's Usua kind of wo DO NOT us	al Occupa nk done d	ation during mos	t of worki	ng	16b. Kind of B	lusiness/Ind	dustry
of filed within at Hyglene. I other than 'vent, its wa	фшо	Elementary/Secondary (0-12)	College	1-4or 5+)	me.		emake				home		
be filed htal Hyg ed other	BeC	17. Father's Name (First, Middle,	Last)						er's Name	(First, Middle,			
ire, INIAIYIAIIQ Z.I.Z.DUJOO s 1 and 2 should be filed within 72 hours efter deeth with the Marylan if Heelth end Mental Hyglene. Item 27 is marked other than "natural", or iteme 23a or 28a-f show other traumatic event, II a Marcial Examiner must be notified at	2		Christia	an Schme			(2)	411	-	ia Schi		24- 4- 2°-	
Mar nd 2 sh alth end 27 ie m r traum		19a. Informant's Name/Relations Barrett E. Kidne				•				Noute Number			
re, IV	1.	20a. Method of Disposition		20b.	Place of Dispo cemetery, cre					Date	20c. Location		
Daltimor Semit. Pages Depertment of I mportant: if it iny Injury or o		XXBurial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (5							s.5/	28/05 C	ockeysv	ille,	MD
Dantimore, I permit. Pages 1 and Department of Heelt Important: If Item 2 any Injury or other once.		21. Signature of Funeral Service	Licensee III							Funera			
SALE.		23 7 rt1. Enter the disease, o	r complications that	caused the dea					4	Ltimore or respiratory ar		Z1Z _	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	•	UMONIA	4								Onset and Death
/Medical Examiner	•	resulting in death)	Due to	(or as a conse	quence of):								
	<u>ē</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	b. — Due to	(or as a consec	quence of):								
cuted nd ransit	Examiner	that initiated events	S c										
6 / 60, ate be executed hysicien and the burial-transit	E	resulting in death) Last	Due to	(or as a consec	quence of):								
Certificate Iding physise as the b	edical		d										
deeth deeth defor u	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 A No 9 ☐ Unknown	1 🗆 Live	utcome of pregn birth 2 Fet mant at time of a nown	al death 3	⊒Ectopic pr ⊒ Other (sp						ate of delive onth	ry Day Year
ords, F.C. requires that the de een signed by the e		Part II. Other significant conditi	ons contributing to	death but not re	sulting in the t	inderlying c	ause giv	en in Part I		23e. Did to	bacco use con	tribute to th	e cause of death?
	ed by	CHRONIC OBSTRU	JCTIVE_PU	LMONARY	DISEAS	SE				1 🗆 Y	es 2 No	3 🗌 Prob	ably 4 Dunknown
a w C	ompleted	RENAL INSUFFIC	CIENCY							24a. Was autop	sy	prior to cor	psy findings available inpletion of cause of
Th Th	O										2 No	death? 1 ☐ Yes	2D No
9	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: N	Inpatient 2] ER/Outpatie	nt 3∐ DC	Oth Oth	00		me 5 ☐ Resid		her (Specify	()
on or of ading Physics. After this of funeral diagrams.	tion: T	27. Manner of Death 1 Natural 5 Pendi 2 Accident invest	28a. Date		28b. Time of Injury		8c. Injun Wor			28d. Describe h			,
DIVISION pittel or Attending ours efter death. lerel Director: After filled in by the funer	ertification:	3 Suicide 6 Could 4 Homicide determ	nined 208. Plac	e of Injury - At h	nome, farm, st	reet, factor	y, office			28f. Location (5 City or Tox		ber or Rura	I Route Number,
4 4 4 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	edical C	29a. Certifier (Check only one) 12 Certifyi 2 Medical	ng Physicien: To the Examiner. On the and ma	e best of my kn basis of examina nner stated.	owledge, dea alluli andlui il	th occurred westigation	at the tin	ne, date ar pinion, dea	nd place,	and due to the o	cause(s) and m date and place,	anner as st	ated.
To the I	Me	29b. Signature and title of certific			>	290	. Licens	e number			29d. Date signe		1
. /	7		Karl				D 3	7254			5/	25	62
101		30. Name and address of person	other and the same	ise of death (Ite	m 23a) (Type	Print)	TOU	SON	MOD.	YLAND	21204		
S Regis	tate trar	THE THE REAL PROPERTY AND ADDRESS OF THE PARTY			lature	Apo			1111	7 hours 11 7 hor	norm of their Bir.		

Model Mode			For Stata Registrar	1	Cer	tificate of D	eath	2. Date of Deat	eg. No. Z. 00	3. Time of Death
45. Facility Name of foreign states any area camber? 45. Facility Name of foreign states and any area camber? 45. Secretal Sample Sam					Kowa1	ewski		Month	Day Ye	ear
Social Security Numbers Security Numbers Security						4b. City, Town, or L			_	
The Street and Number Top. Street and Number Top. Children Top. Childre				7 Ago //p	ure last hirthday)			9 Date of Birth		
Top. State Top. Country Top. According Top. Country Top.	uneral rector		212-01-3996	RM OFF				(Month, Day,	,1919 M	aryland
23a. Part I. Enter the disease, or complications that descend the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PROSTATE CANCER	iffed at	ctor	10a. State 10b. County							10d. Inside City Limits 1½∏¥es 2 ☐ No
23a. Part I. Enter the disease, or complications that desend the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate filterian Bayasian and Clear in the Complete of th	prince	Dire						1	-	
239. Part 1. Enter the diseale, or complications that desired the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line.	Dust	erai						accifu Vas ar Na-		
239. Part 1. Enter the diseale, or complications that desired the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line.	ineri	Fun		Armed Forces?			, Mexican, Puert	o Rican, etc.)	Black, \	White, etc.
239. Part 1. Enter the diseale, or complications that desired the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line.	Exam	by		If Yes. Give		☐ Yes 21xx No	Specify:		Specify:	White
239. Part 1. Enter the diseale, or complications that desired the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line.	dicat	eted			(Give I	kind of work done du	ion ring most of wor	king	16b. Kind of Busin	ess/Industry
23a. Part I. Enter the diseale, or complications that deseed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Bawwen	e Me	mpi	Elementary/Secondary (0-12)		life. L	OO NOT use retired)		_		
23a. Part I. Enter the diseale, or complications that desired the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or near failure. List only one cause on each line.	int, it				L€			ne (First, Middle, M		OV t.
23a. Part I. Enter the diseale, or complications that desert the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line.	atic eve	To Be	Francis Kowa	alewski					· · · · · · · · · · · · · · · · · · ·	
23a. Part I. Enter the diseale, or complications that deseed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Bawwen Christ Bawwen Charles Bawwen Christ Bawwen Christ Bawwen Christ Bawwen Christ Baw	traum									
23a. Part I. Enter the diseale, or complications that deseed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Bawwen	thar				Ob. Place of Dispos	sition (Name of				
23a. Part I. Enter the disease, or complications that believed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Bawwen interval Baww	y or c		1 Surial 2 Cremation 3 □F		•			/2005	Raltimo	re Md
23a. Part I. Enter the diseale, or complications that believed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Bawwen interval Baww	injur									
Shock, or heart failure. List only one cause on each line. PROSTATE CANCER PROSTATE CANCER PROSTATE CANCER Properties Proper	any onc		Port know	low						
PROSTATE CANCER Due to (or as a consequence of):			23a. Part1. Enter the disease, or composhock, or heart failure. List only o	lications that daused the	death. Do not ente	er the mode of dying,	such as cardiac	or respiratory arre	est,	Interval Between
Second of the past 12 months? 1 Yes 2 No 3 Probably 4 Pregnant at time of death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Proposition of cause of death? 1 Yes 2 No 3 Probably 4 Proposition of cause of death? 1 Yes 2 No 3 Probably 4 Proposition of cause of death? 1 Yes 2 No 3 Probably 4 Proposition of cause of death? 1 Yes 2 No 3 Probably 4 Proposition of cause of death? 1 Yes 2 No 3 Probably 4 Proposition of cause of death? 1 Yes 2 No 3 Probably 4 Proposition of cause of death? 1 Yes 2 No 3 Probably 4 Proposition of cause of death? 1 Yes 2 No 3 Probably 4 Proposition of cause of death? 1 Yes 2 No 3 Probably 4 Proposition of cause of death? 1 Yes 2 No 3 Probably 4 Proposition of cause of death? 1 Yes 2 No 3 Probably 4 Normal Proposition of cause of death? 1 Yes 2 No 3 Probably 4 Normal Proposition of cause of death? 1 Yes 2 No 3 Probably 4 Normal Proposition of cause of death? 1 Yes 2 No 3 Probably 4 Normal Proposition of cause of death? 1 Yes 2 No 3 Probably 4 Normal Proposition of cause of death? 1 Yes 2 No 3 Probably 4 Normal Proposition of cause of death? 1 Yes 2 No 3 Probably 4 Normal Proposition of cause of death? 1 Yes 2 No 3 Probably 4 Normal Proposition of cause of death? 1 Yes 2 No 3 Probably 4 Normal Proposition of cause of death? 1 Yes 2 No 3 Probably 4 Normal Proposition of cause of death? 1 Yes 2 No 3 Probably 4 Normal Proposition of cause of death? 1 Yes 2 No 3 Probably 4 Normal Proposition of cause of death? 1 Yes 2 No 3 Probably 4 Normal Proposition of cause of death? 1 Yes 2 No 3 Probably 4 Normal Proposition of cause of death? 1 Yes 2 No 3 Probably 4 Normal Proposition of cause of death? 1 Yes 2 No 3 Probably 4 Normal Pr	iner	aminer	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	nsequence of):					
1 Yes 2 No 3 Probably X Unknown	ırial-t	பி		Due to (or as a co	nsequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	as the bu	ا شا		1 Live birth 2	Fetal death 3					
24a. Was an autopsy performed? 1	ached for use as the bu	hysician/M	in the past 12 months? 1 □ Yes 2 □ No	9□ Unknown					acco use contribu	ite to the cause of death?
autopsy performed? The performed The performed The performed? The performed o detached for use as the bu	0	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ot resulting in the un	nderlying cause giver	n in Part I.	23e. Did tot			
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other: 4 Nursing Home 5 Residence	be detached	by P	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ot resulting in the ur	nderlying cause giver	n in Part I.			
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 2 No 28c. Injury a	2 should be detached	by P	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ot resulting in the ur	nderlying cause giver	n in Part I.	1 ☐ Ye	n 24b. Wer prio deat	Probably 4 Unknown re autopsy findings available r to completion of cause of th?
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year)	2 should be detached	e Completed by P	in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions co	entributing to death but no	ot resulting in the ur		26. Place of Dea	1 Yes 24a. Was a autops perform 1 Yes 2	n 24b. Wer prio dea: 21 No 3 [24b. Wer prio dea: 21 No 1	Probably 4X Unknown re autopsy findings available r to completion of cause of th? Yes 2 No
29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Certifier (Check only one) 29d. Date signed (Month, Day, Year)	2 should be detached	To Be Completed by P	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions co	ontributing to death but no	2 ☐ ER/Outpatien	t 3□ DOA ^{Other}	26. Place of Dea	24a. Was a autops perforr 1 Yes 2 atth (Check only onlone 5 Reside	n 24b. Wer prio dea 2 No 1 = 0 Prior prior dea 2 No 1 = 0 Prior prior dea 2 No 1 = 0 Prior prior	Probably 4X Unknown re autopsy findings available r to completion of cause of th? Yes 2 No
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year)	funeral director, page 2 should be detached	To Be Completed by P	in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions co 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	ntributing to death but no Hospital: 1 ☐ Inpatient 28a. Date of Injury	2 ☐ ER/Outpatien 28b. Time of	t 3 DOA Other	26. Place of Dea 4 □ Nursing H	24a. Was a autops perforr 1 Yes 2 atth (Check only onlone 5 Reside	n 24b. Wer prio dea 2 No 1 = 0 Prior prior dea 2 No 1 = 0 Prior prior dea 2 No 1 = 0 Prior prior	Probably 4X Unknown re autopsy findings available r to completion of cause of th? Yes 2 No
29b. Signature and (itle of certifier) 29c. License number 29d. Date signed (Month, Day, Year)	in by the funeral director, page 2 should be detached	ertification; To Be Completed by P	in the past 12 months? 1	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye)	2 ER/Outpatien 28b. Time of Injury At home, farm, stre	t 3 DOA Other 28c, Injury a Work? M 1 TY	26. Place of Dea 4 □ Nursing H	24a. Was a autops perform 1 Yes 2 autops perform 5 Reside 28d. Describe ho	n 24b. Wer prio dea 22 No 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Probably 4X Unknown re autopsy findings available r to completion of cause of th? Yes 2 No **Specify** NOSPICE**
D43725 5/31/05	in by the funeral director, page 2 should be detached	Certification; To Be Completed by P	in the past 12 months? 1	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye) 28e. Place of Injury building, etc. (S	2 ER/Outpatien ar) 28b. Time of Injury At home, farm, stre	t 3 DOA Other 28c. Injury a Work? M 1 Ye eet, factory, office	26. Place of Dea 4 \(\text{Nursing H} \) at es 2 \(\text{No} \) a, date and place	24a. Was a autops perform 1 Yes 2 ath (Check only on lome 5 Reside 28d. Describe hours of the City or Town and due to the can appear to the can and due to the can appear to the can and due to the can appear to	as 2 □ No 3 [ny y y y y y y y y y y y y y y y y y	Probably 4X Unknown re autopsy findings available r to completion of cause of th? Yes 2 No (Specify) HOSPICE or Rural Route Number, er as stated.
	in by the funeral director, page 2 should be detached	edical Certification; To Be Completed by P	in the past 12 months? 1	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye) 28e. Place of Injury building, etc. (S	2 ER/Outpatien ar) 28b. Time of Injury At home, farm, stre	t 3 DOA Other 28c. Injury a Work? M 1 Ye eet, factory, office	26. Place of Dea 4 ☐ Nursing H at bes 2 ☐ No a, date and place nion, death occur	24a. Was a autops perform 1 yes 2 autop	as 2 No 3[n y 24b. Wer prio dea dea dea dea no place, and manne ate and place, and	Probably 4X Unknown re autopsy findings available r to completion of cause of th? Yes 2 No **Specify** HOSPICE** or Rural Route Number, er as stated, due to the cause(s)

DHMH 17 Rev 1/2001

Decoder Name Print Modes (ast) Center Harley Kellogg, Jr. Color of Damber Center Harley Kellogg, Jr. Color of Damber Center Harley Kellogg, Jr. Color of Damber Center Cent				For State Registrar	State of I	Maryl	and / Depa <i>Cel</i>	artment of rtificate o			-	giene Reg. No.	711111	18301
Robert Harley American (From established year search and muthod) Anne Arunde 1 Medical Center Anne Arunde 1 Medical Center Fundral Director Fundral Fundr					e, Last)						2. Date of De	ath		3. Time of Death
Standard Anne Arundel Medical Center Fundamental Company Security Number Secu				Robert	Harley		Kellogg	, Jr.						0150 M
Control Cont				4a. Facility Name (If not institution	n, give street and number	er)			, or Location	on of Deat	h	4c.	County of Death	
Order Control of Contr				Anne Arundel	Medical Cer	nter		Anna	polis				Anne An	cundel
Discretion of the processor of the proce		Funeral		5. Social Security Number			yrs. last birthday)				8. Date of Bir	th V Year)	9. Birth	place (State or Foreign
100. Sizes 100. County 1				046-05-6347	1 X M 2 F	95	Yrs.	IVIOTILIS Day	rs Hour	5	Dec. 9	, 19		sachusetts
The part of the pa		pc ,				10-	Oit Town							
The part of the pa		aryla shov	_	,		100.								•
The part of the pa		8a-f	ctc		Arundel		Gambril							
The part of the pa		or 2	E E	10e. Street and Number				10f. Zip Code	Э			10g. Citi	zen of What Cou	intry?
The part of the pa		ath v	ia	1081 Snowhill										
The part of the pa		er de tems	nue		Armed Force	s?	in U.S. 13.	Was Decedent of If Yes, specify C	f Hispanic uban, Mexi	Origin? (S can, Puer	Specify Yes or No to Rican, etc.)	-		
The part of the pa	36	s aft	yΕ		If Yes, Give			1□Yes 2 X X	lo Spec	ify:			Specify: V	Vhite
The part of the pa	8	hour	P P			5.	16a Dacar	dont's Lleval Oo	ougation.		<u> </u>	16h Ki	ind of Pusinoss/I	ndusta
The part of the pa	5	n 72 "na	lete	(Specify only highe	st grade completed)		(Give	kind of work do	ne during m ired)	ost of wo	rking	100. KI	ind of businessy	idustry
Physician Medical Examiner Ph	12	withi ene. than	E C	Elementary/Secondary (0-12)		or 5+)							Hognita	1
Physician Medical Examiner Ph	5	filed Hygi thar		17. Father's Name (First, Middle,			повр	TCGT HII,	-		me (First, Middle,	Maiden		**
Physician Medical Examiner Ph	an	d be antal cad o	980						J	ennv	Hamm			
Physician Medical Examiner Ph	<u> </u>	shoul od Me mari	F	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	na Address (Stre				er. Citv o	r Town, State, Z	ip Code)
Physician Medical Examiner Ph	<u>≅</u>	id 2 s ith ar 27 is treu	1			Son)								,
Physician Medical Examiner Ph	Ģ	1 an Hea tam 3			1000 111 (1					,				own, State
Physician Medical Examiner Ph	<u></u>	nt of nt of t: If it				ue				E / 25	7 / 2005	D	1 77.5 1 1	O.T.
Physician Medical Examiner Ph	를	urtme urteni njury				1 2				·	7 2003	KOC	ку ніті,	GT
Physician Medical Examiner Ph	Ba	Department Department	. ,	13: 0.0				Hardes	ty Fu	nera]	L Home,	P.A.		
Physician Modical Examinor Physician Modical Examinor Physician Modical Examinor Physician Modical Examinor Physician Modical Examinor Physician Modical Examinor Physician Modical Examinor Physician Modical Examinor Physician Modical Examinor Physician Modical Examinor Physician Modical Examinor Physician Modical Examinor Physician Modical Examinor Physician Modical Examinor Physician Modical Examinor Physician Physician Modical Examinor Physician			23a Part1 Enter the disease of	complications that cause	sed the c	death. Do not ent	12 Rid	gely	Aveni as cardia	ie, Annaj	poli	s, MD 21		
Part Color				shock, or heart failure. List	only one cause on each	line.)	or the mode of c				11001,		Interval Between Onset and Death
Due to (or as a consequence of): Cause (Disease or Injury to the control of the country) to the country of t				disease or condition	a	1/	ulner	rang	2	معاد	na			
The part of the pa				,	Due to (or	as á con	isequence of):	. ()	1	\sim				
Section Part	н		<u>.</u>	Sequentially list conditions,	b	25 2 000	(Type	entin	500					
Section Part	_	ed Isit	nine	cause. Enter Underlying	₹ 200 10 (01			0 1		. 1	610-	· On	0.1	
Section Part	_	and and Il-trar	xan	that initiated events	C. Due to (or	as a con	isequence of):	NICIO	me	70	Henry		cook	
FEMALE 23b. Was decedent pregnant in the past 12 months? 1 1 1 2 Fetal death 2 1 1 2 1 1 2 1 2 1 2 1 2 2	09	be e ician buria	aiE				, ,						0	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death of part of the part of	387	phys the	dic		d									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death of part of the part of	×	ding se at	/Me		23c. If yes, outcor	ne of pre	egnancy						22d Date of deli	, , , , , , , , , , , , , , , , , , ,
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death of part of the part of	Bo	atten for u	ian	in the past 12 months?	1☐Live birth	2 🗆 F	Fetal death 3							
The state of the s	o.	he de	ysic				or death 3L	J Other (specify)						
25. Was case referred to medical examiner? 1	σ.	that the by detail		Part II. Other significant conditi	ons contributing to deatl	h but not	resulting in the u	nderlying cause	given in Pa	ırt I.	23e. Did t	obacco u	se contribute to	the cause of death?
25. Was case referred to medical examiner? 1	ds,	sign sign d be			Dine	2~	ha				10	Yes 2	ZNo 3 □ Pro	bably 4 Unknown
25. Was case referred to medical examiner? 1	Ö	requ been shout	ete		A a		2 00				04- 146-		045 14455 504	and Cadian and India
25. Was case referred to medical examiner? 1	ĕ	e law has je 2 s	mpi		Depre	2 V	1000				autor	osy	prior to c	
27. Manner of Death Shatural 1	<u>=</u>		S											2□ No
27. Manner of Death Shatural 1	Viti.	ician Sertifi ector	0	examiner?						ace of De	ath (Check only o	ne)		
The state of the s		this a	-		1 inpa		1	I 3 DOA	4 🗆	Nursing I	, -			ify)
The state of the s	n o	ing f	ion	1 Natural 5 ☐ Pendir	ng (Month,	Day Yea	r) Injury	V	Vork?		28d. Describe i	now injur	y occurred	
The state of the s	Sic	tand leath tor: the f	cat	Z / tooldont	not be					□NO	206 1	01	111	-10- 1-11
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed carse of death (Item 23a) (Typ. Print) 30. Name and address of person who completed carse of death (Item 23a) (Typ. Print)	⋈	or At fter (Dirac in by	ıţ	dotom	nined 286. Place of			eet, factory, offic	e e					ai Houle Number,
30. Name and address of person who completed carse of death (Item 23a) (Typ. Print) 30. Name and address of person who completed carse of death (Item 23a) (Typ. Print) 30. Name and address of person who completed carse of death (Item 23a) (Typ. Print) 30. Name and address of person who completed carse of death (Item 23a) (Typ. Print) 30. Name and address of person who completed carse of death (Item 23a) (Typ. Print) 30. Name and address of person who completed carse of death (Item 23a) (Typ. Print)		pitel urs a aral (non oration to Consider	an Obvoicione Takke ba	-1 -6	land de la de el		. No. 1					
30. Name and address of person who completed carse of death (Item 23a) (Typ. Print) 30. Name and address of person who completed carse of death (Item 23a) (Typ. Print) 30. Name and address of person who completed carse of death (Item 23a) (Typ. Print) 30. Name and address of person who completed carse of death (Item 23a) (Typ. Print) 30. Name and address of person who completed carse of death (Item 23a) (Typ. Print) 30. Name and address of person who completed carse of death (Item 23a) (Typ. Print)		Hos 24 ho Fund tely f	lica	(Check only 2 Medical	Examiner: On the basis	s of exan	knowledge, death nination and/or in	occurred at the vestigation, in m	y opinion, o	and placedeath occ	e, and due to the urred at the time,	cause(s) date and	and manner as I place, <i>a</i> nd due	siated. to the cause(s)
30. Name and address of person who completed carse of death (Item 23a) (Typ. Print) 30. Name and address of person who completed carse of death (Item 23a) (Typ. Print) 30. Name and address of person who completed carse of death (Item 23a) (Typ. Print) 30. Name and address of person who completed carse of death (Item 23a) (Typ. Print) 30. Name and address of person who completed carse of death (Item 23a) (Typ. Print) 30. Name and address of person who completed carse of death (Item 23a) (Typ. Print)		thin thin the thin th	New Year		-	sidled.		29c Line	ense numb	er		29d Dat	e signed (Month	. Dav. Year)
04 Data Elad (Marth, Day, Vent) 00 Dayletoute Classics		F 3 F 8		255. Olgitatoro and title or softine			\mathcal{Q}		7	100	100			_
04 Data Elad (Marth, Day, Vent) 00 Dayletoute Classics		1			WIL	-	e		0	216	591	U	0 06	y -4 3
04 Data Elad (Marth, Day, Vent) 00 Dayletoute Classics	Y) '		1 /		-			roli	1-7	Inve.	Cot.	100 I)	La HOT DIENE
				31. Date filed (Month, Day, Year,			1035		, 0 0			ب ر	100 71	100 my x 1042
State 31. Date filed (Mohin, Day, Year) Registrar IIIN 0 1 2005					A		4	legal 5						,

ORIGINAL

DHMH 17 Rev 1/2001

			1 - For State Registrer	State of Marylar	nd / Depa	artment of			3	ilgans
			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	rtificate of	Death		g. No.	10000
	Physici		MARA DOLLAR	OFF KOER	BER			2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s		A).	4b. City, Town,	or Location of Deatl		4c. County of De	
	-Xaiiii		GOOD SAMARIT	AN HOSPIT	/, –	BALTIN	MORE C	ITY)	BALTIN	MORE
	Funeral Director		5. Social Security Number 215 289674 6. Sex	7. Age (In yrs. 72	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Sept. 6,	Year) 9. Bi	rthplace (State or Foreign Country)
	and w		Usual Residence of Decedent 10a. State 10b. County	10c Ci	ty. Town or Lo	cation				10d. Inside City Limits
	be filed within 72 hours after death with the Maryland and Hygliene. All Hygliene did they filene dither then "naturel", or terms 23s or 28s-f show other then "naturel", or terms and the notified at event, the Medical Examinar must be notified at	jo	Maryland N/A		Baltir					1 X Yes 2 No
	r 28a	Director	10e. Street and Number		Darti	10f. Zip Code		10	g. Citizen of What C	Country?
	23a o	ai D	2920 Overland Av	enue			21214		United S	tates
	er dea tems	Funerai		 Was Decedent Ever in U Armed Forces? 	.S. 13.	Was Decedent of f Yes, specify Cub	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh	
50	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Novorced	1		1 □ Yes XX No	Specify:		Specify:	White
2-003p	2 hou		15. Decedent's Educ	ation	16a. Deced	dent's Usual Occu	pation		6b. Kind of Busines	
7	ithin 7 19.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)			during most of wor		-14- 0'4	D 1:
7	lled w lygier her th	Cor	12 yrs. 17. Father's Name (First, Middle, Last)		Coll	nputer Op			alto. Cit	y Police
yland	e d la la e	o Be	Howard Nice					_{ne (First, Middle, M} izabeth	Callahan	
<u></u>	should be nd Menta marked imatic ev	2	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailir	ng Address (Stree	<u> </u>		City or Town, State,	Zip Code)
Š.	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 le marke any injury or other treumatic ones.		Mrs. Carol L. Darne		217	ecoy Dri	ive Havre	e de Grac	e, Maryla	nd 21078
	ages int of H		20a. Method of Disposition 1 X Burial 2 Cremation 3 R			sition (Name of natory or other pla			Oc. Location - City o	
ballimor	nit. Parantme ortant injury		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License			Mem. Par	-		Baltimor 5305 Harfo	e, Maryland
Ö	Department Department Impo		Macicy.	Michael E. Ca	парр		J. Ruck,		Baltimore,	
т			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the deat	h. Do not ent			11101		Approximate Interval Between
E	Physician		Immediate Cause (Final disease or condition	C	V A					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	1					
		-	Sequentially list conditions, b	Due to lor as a cor.s		ion				
¥	uted insit	Examiner	cause. Enter Underlying Cause (Disease or injury	Muse		O Time	tanctio.			
ĵ	exect an and rial-tra	Exa	that initiated events cresulting in death) Last	Due to (or as a conseq			, tolviaro			
00/0	cate be executed ohysician and the burial-transit	licai	d							
ŏ	w requires that the death certifics been signed by the attending pt should be detached for use as the	Physician/Med	IF FEMALE:	3c. If yes, outcome of pregna		The second second				
ממ	atten for us	cian	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of o	Ideath 3□	Ectopic pregnance Other (specify)	Ey .		23d. Date of de Month	blivery Day Year
į	t the d by the ached	hysi	1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown	9□ Unknown						
r n	gned gned be det	by P	Part II. Dther significant conditions con		-		ven in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
acords,	equin sen si nould I	ted	Aspiration Pr	eumonies,	ISL	hemie	(oliHS)	1 ☐ Yes	s 2 □ No 3 🗗 🗗	robably 4 Unknown
ב ב	has bi	Completed	DM, GERD					24a. Was an autopsy	prior to	utopsy findings available completion of cause of
ב כ	n: Thi licate r, pag							perform 1□ Yes 2	□ NO 1 □ Ye	s 2110
VII d	sicial s certifirecto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	ER/Outpatien	t 3 DOA Ott		th Check onl one	nce 6 □Other (Spe	- % .1
5	ding Physician: The lav h. Affer this certificate has funeral director, page 2	\vdash	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Inju	ry at	28d. Describe how		эспу)
NISIOI I	endin sath. or: Aft he fur	atio	1 🖾 Natural 5 🗆 Pending investigation	(Monal, Day 16al)	Injury		Yes 2 No			
	or Att after de Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or F State)	ural Route Number,
	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 54 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medicel Exemin	ician: To the best of my kno er: On the basis of examina and manner stated.	tion and/or inv	estigation, in my	opinion, death occu	rred at the time, dat	te and place, and du	e to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed (Mon	Baltimene 21239
			> Um _ le	, wil		00	00 6053	9 1	5-25-0	5
	3		30. Name and address of person who con	npleted cause of death (Item	23a) (Type, I	Print)	0 Etal 1	och Raver	Blud,	Baltimone
			31. Date filed Menth Days Mary or	M) (TOO d S	amavi b	cin tospile	wil, so	- (* '	MD	21239
	Sta Registr		4 JUN 4 ZUU5	Beern B	Sports	P				

Many Doloves Knerber

			1- State of Maryla		artment of H							
			Registrar 1. Decedent's Name (First, Middle, Last)		timeate of t	Jean	2. Date of Deat		3 Time of Deat	h ()		
	Physici /Medic		Joseph Andrew	Kukuck	:a		Month	30 2	rear 1.30	M		
	Examin		4a. Facility Name (If not institution, give street and number)		, ,	Location of Death	110	4c. County o				
			Levindale	to an hillate to a		ore City If Under 24 Hrs.	To 5 . (5:4)		N/A			
	Funeral Director		5. Social Security Number 6. Sex 1 № 4 2 ☐ F 81	i. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, March 3	Year)	Birthplace (State or Fore Country) Maryland	эign		
by			Usual Residence of Decedent				Trial Cit 3	01,1324	rial y Lanu			
	arylan show	_		ity, Town or Lo	,				10d. Inside City Limi			
	he Ma	Director		ltimore	-		· · · · · · · · · · · · · · · · · · ·		1 ☐ Yes 2 ☐ N			
	with tage or 3	급	3823 Monterey Road		10f. Zip Code 2121	10		0g. Citizen of WI				
	death ms 23	Funeral	11 Marital Status 12 Was Decedent Ever in I	J.S. 13.1	Was Decedent of Hi If Yes, specify Cuba		pecify Yes or No-		- American Indian,			
9	after or Ital	Ţ.	Armed Forces? 1 Never Married 2 Married 1 Yes, Give WW I		lf Yes, specify Cuba 1 □ Yes 2 🕱 No		o Rican, etc.)		, White, etc.			
003	ural',	d by						Specify:	White			
21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or Itams 23a or 28e-f show Ita M. die Exertiner: wat be matthed at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa kind of work done o DO NOT use retired	ation <i>furing most of wor</i> th	king	ng 16b. Kind of Business/Industry				
12	within iene. than	dwo	Elementary/Secondary (0-12) College (1-4or 5+)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Salesmar			Car :	Sales			
	e filed Il Hyg othar	BeC	17. Father's Name (First, Middle, Last)				ne (First, Middle, I	Maiden Sumame				
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene the feath and Mental Hygiene titan 27 is marked other than "natural", or Itams 23a or 28e-f show other traumatic event, I'm Madical Exerciting to another traumatic event, I'm Madical Exerciting to a second	ToE	Joseph Kukucka			Heler		Unknown mber, City or Town, State, Zip Code)				
Mai	d 2 sh th and th sr 7 is rr traurr		19a. Informant's Name/Relationship (<i>Type</i> , <i>Print</i>) Alma L. Kukucka-Daughter		ng Address <i>(Street a</i> Montere y		ra/Route Number lltimore,	•				
ē,	s 1 and 3 1 Health Itam 27 other tr			Place of Dispo	sition (Name of matory or other place				City or Town, State			
altimore,	Pages nent of I int: If its iry or o		1 🔀 Burial 2 □ Cremation 3 □ Removal from State `4 □ Donation 5 □ Other (Specify)		nislaus 6/1/05 Baltimore, MD							
att	permit. Pages Department of Important: If i any injury or one		21. Signature of Funeral Service Licensee	22	2. Name and Addres	ss of Facility Bal	timore.	MD 2121	4			
<u> </u>	89789		Yan I Hurtout of	LE	eonard J.	RUCK, IT	<u>10. 5305</u>	Hartor	d Rd.			
н			23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each life.	ith. Do not ent			And the second		Approximate Interval Between Onset and Death			
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Myc	rorde	I rent	herlio	ei	2 lhery			
	Examiner		Due to (or as a conse	quence of):	a. T	- //	hulio			a		
		ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	quence of)	- are	7	due	- Me	16 Menl	1		
H	cuted nd ransit	Examiner	that initiated events			0						
,0	be executed sician and burial-transit		resulting in death) Last Due to (or as a conse	quence of):								
8760,	ate hy:	dicai	d									
9 X	eath certific attending p	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregr	iancy				23d Date	of delivery			
Вох	death a atter d for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	al death 3	Ectopic pregnancy Other (specify)			Mont.	,			
P.O.	that the di ed by the detached	hysi	9 Unknown 9 Unknown									
S, F	es tha igned be dei		Part II. Other significant conditions contributing to death but not re	sulting in the u	nderlying cause give	en in Part I.			oute to the cause of death?			
ord	w require been si should t	ted	more comen or	1			1 □ Ye	s 2 □ No 3	Probably 4 Dunknov	wn		
Records,	e law has b	Completed by					24a. Was a autops perform	v pri	ere autopsy findings availab for to completion of cause o eath?	ble of		
			05.10				1 ☐ Yes 2	2000 1E	Yes 2 No			
Vital		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 → 43 o Hospital: 1 ☐ Inpatient 2 □	☐ ER/Outpatien	at 3 DOA Othe	20 %	th (Check only on ome 5 ☐ Reside		(Specify)			
0	g Phya er this eral di	 	27. Manner of Death 28a. Date of Injury	28b. Time of	The second second second		28d. Describe ho			-		
ior	Attending F death. ctor: After y the funer	atio	Z Accident investigation	приту		res 2 □ No						
Division	or Atto	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At I building, etc. (Spec	nome, farm, str	eet, factory, office		28f. Location (St. City or Town	Location (Street and Number or Rural Route Number, City or Town, State)				
	pitel o		29a. Certifier 1 SCertifying Physician: To the best of my kn	auladaa daat		n data and alone	and due to the co					
	To the Hospitel or Attending within 24 hours after death. To the Funarel Diractor: After completely filled in by the fune	Medical	29a. Certifier (Check only one) 1 StCertifying Physician: To the best of my kr 2 Medicel Examiner: On the basis of examiner and manner stated.	ation and/or in	vestigation, in my of	pinion, death occur	red at the time, da	ause(s) and mani ate and place, an	d due to the cause(s)			
	To the Hospitel or Attendin within 24 hours after death. To the Funaral Diractor: At completely filled in by the fu	Me	29b. Signature and title of certifier		29c. License	number	25	9d. Date signed ((Month, Day, Year)			
	1		Majan ms -		76	41817	9	1ay-3	12,3002			
	6		30. Name and address of person who completed cause of death (Ite	m 23a) (Type,	Print)	C1	12 20	lb Mar	0.5 2	_		
	Sta	10	31. Pate filed (Month, Day, Year) 327 Registrar's Sign	y w	Berma	ure w	~ D4	my	(000) 2 141	7		
	Sta Registr		JUN 0 1 2005	1. 608	also .				`			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State State of Death Registramenn TTEM #7 PER FH C844 6/01/05 JH Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 29 2005 W **Physician** KANDEL DOROTHY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner LEVINDALE HEBREW HOME BALTIMORE N/A 8. Date of Birth (Month, Day, Year) 02/14/1914 If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2 € F 90 MD Director 213-09-5550 91 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County ? is markad other than "natural", or Itama 23a or 28a-f show traumatic evant, the Modical Examinar must be notified at 1 ☐ Yes 2√ No Director MD N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 3105 BANCROFT ROAD APT. B 21215 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) e filed within 72 hours after all Hygiene. 1 ☐ Never Married 2 ☐ Married WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) LADIES CLOTHING RETAIL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fill and Mental H Be **FRANK** LEVINSON MEYER SARAH ၉ permit. Pages 1 and 2 sh.
Department of Health and Important: If item 27 is ma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3105 BANCROFT ROAD APT. B - BALTIMORE, MD 21215 MAURY KANDEL / SON 20b. Place of Disposition (Name of DETH ISAAC ADATH ISAAC ADATH 20a. Method of Disposition 1 ☑ Burgal 2 ☐ Crem Date 20c. Location - City or Town, State 2 Cremation 3 Removal from State 5 Other (\$ pecify) 05/29/2005 BALTIMORE, MD n@ral Servi SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part Nenter the disease, or conshock, or heart failure. List only blidations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset, and Death Immediate Cause (Final disease or condition resulting in death) MYKashe **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons ---- ce of): Examiner burial-transit senson or as a consequence of): attending physician 68760, Physician/Medical use as the Box (IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. | 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attanding PI
 A hours after death.
 Funaral Diractor: After the Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \(\text{Homicide} To the Hospital within 24 hours at To the Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUN 0 1 2005

24346

of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

29c. License number

Belvedere auc

29d. Date signed (Month, Day, Year)

			1 - For State C	of Maryland / Dep <i>Ce</i>	artment of F			giene	5 8308
	Physici		1. Decedent's Name (First, Middle, Last)	KI	AUFM	AN	2. Date of Dea	Day	Year 3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give street and nu	ımber)	4b. City, Town, o	or Location of De	eath	4c. County	
			NORTHWEST HOSPITAL CENT	ER 7. Age (In yrs. last birthday,	RANDALI If Under 1 Year		rs 9 Date of Right	BALTI	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 K F	85 Yrs.	Months Days	Hours M		1920	9. Birthplace (State or Foreign Country) MD
	land W		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
	ith the Marylar or 28a-f show se notified at	ctor	MD N/A	BALT	IMORE				1 (X)Yes 2 ☐ No
	with the	Dire	10e. Street and Number	UE #E07	10f. Zip Code	01015		10g. Citizen of W	/hat Country? USA
	ns 234	erai	6210 PARK HEIGHTS AVEN		Was Decedent of h	21215	(Specify Yes or No-	14. Race	o - American Indian,
36	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28a-1 show the Medical Examirer must be neithed at	by Funeral Director	Amed F. 1 Never Married 2 Married 1 Yes If Yes, G.	2 X No	If Yes, specify Cub 1 ☐ Yes 2 💢 No	an, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	Black Specify:	k, White, etc.
215-0036	2 hour	ted b	15. Decedent's Education	16a. Dece	dent's Usual Occur	oation .		16b. Kind of Bu	siness/Industry
21215		Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+)	P kind of work done DO NOT use retire MAKER	during most of v d)	vorking	OWN HOM	E
Maryland	ould be filed Mental Hygi tarked other tatic event, II	Be	17. Father's Name (First, Middle, Last) SAMUEL	СОНЕ	N	18. Mother's N	lame (First, Middle,	Maiden Sumame UNOBTAIN	'
aryl	2 should and Men Is marke sumatic	2	19a. Informant's Name/Relationship (Type, Print)				Rural Route Numbe		
_	1 and 2 Health a tem 27 is		SAMUEL HIRSCHMAN / SON		OUTH RID	GE TRAIL			
lore	Pages 1 nent of H int: If itel iry or oth		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from	State	matory or other pla		Date (21 / 200 F		City or Town, State
Baltimore	permit. Pages 1 a Department of Her Important: If item any injury or otha		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Faneral Service Licensee		MEMORIAL 2. Name and Addre		SOL LEVINS		LLSTOWN, MD OS., INC.
Ä	Depa fmpo any is		1 /and	- 8	900 REIS	TERSTOWN	ROAD - F	PIKESVIL	LE, MD 21208
	Physician		23a. Part1. Enter the disease, or complications that shock, or yeart failure. List only one cause on Immediate Cause (Final disease or condition	caused the death. Do not eneach line.	ter the mode of dyir	ng, such as card	iac or respiratory ari	rest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	(or as a consequence of):	, t	0.1		D .	4
		Jer	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	(or as a consequence of):	morre	pni	moneny	aser	i e
	cate be executed obysician and the burial-transit	Examin	trial initiated events	(01.00.0.000000000000000000000000000000					
8760,	sician s burial	icai E	Due to	(or as a consequence of):					
9	rtificate ng phy: as the	e	U						
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?	nant at time of death 5	⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	y		23d. Date Mon	e of delivery ath Day Year
s, P	res that igned b be deta	by	Part II. Other significant conditions contributing to c	death but not resulting in the u	ınderlying cause giv	ven in Part I.	~ \		bute to the cause of death?
ord	v requir been si should	eted	Broves orjean	nis			~		3 Probably 4 Unknown
Records,	The law ite has to age 2 s	Completed					24a. Was a autop: perfor	sy pi med? di	Vere autopsy findings available rior to completion of cause of eath? ☐ Yes 2 ☐ No
Vital	Physician: this certifica ral director, p	BeC	25. Was case referred to medical examiner?				eath (Check only or		
of	Physi r this c ral dire	- To	1 ☐ Yes 2 No Hospital: 1 1 27. Manner of Death 28a. Date	npatient 2 ☐ ER/Outpatie of Injury 28b. Time of		4 🗀 Nursing	Home 5 ☐ Resid	ence 6 Othe	
ion	Attanding death. ctor: Afte y the fune	atior	Natural 5 Pending (Mor	nth, Day Year) Injury	Wor	rk? Yes 2□No		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Division	of or Atta	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place determined build	e of Injury - At home, farm, st ling, etc. (Specify)	reet, factory, office		28f. Location (S City or Tow		or or Rural Route Number,
	To the Hospitel or Attanding Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely illied in by the funeral director, page 2	edical C	29a. Certifier (Check only one) Certifying Physician: To the 2 Medical Examiner: On the band man	e best of my knowledge, dear pasis of examination and/or in ther stated.	th occurred at the time the ti	me, date and pla ppinion, death oc	ice, and due to the d courred at the time, o	ause(s) and mar date and place, a	nner as stated. nd due to the cause(s)
	with Tot Com	¥	29b. Signature and title of certifier	ms	29c. Licens	977	Y	29d. Date signed	(Month, Day, Year) -B 2005
18) (30. Name and a dre s of person who completed cau	se of death (Item 23a) (Type	Print)	on B	unie.	mo.	20061
	Sta			Registrar's Signature	7				
DH	Registi MH 17 Rev 1/2	-4.1	JUN 0 1 200	5 Bleeve L	4 Sports				

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY **Physician** STANLEY PAUL KELLY 28 2005 4:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 1110 ANGLESEA STREET BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) MARCH 5, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1₩ 2□ F 76 214-26-2452 Director MD Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show 1 TyYes 2 □ No Director BALTIMORE MD. N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1110 ANGLESEA STREET 21224 UNITED STATES Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or Items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No ItXes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify: þ 3 ₩ Widowed 4 Divorced WHITE "naturel', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) ELECTRICIAN ELECTRICAL permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 Is marked othe any njury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSEPH KELLY LILLIAN MILWICZ ္ဝ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) VINCENT KELLY/SON 7112 GOUGH STREET, BALTIMORE, MARYLAND 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 KBurial 2 Cremation 3 Removal from State 4 □Donation MT.CARMEL CEMETERY 6/1/05 BALTIMORE, MARYLAND 5 Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signature of Funeral Service Licensee 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 9WAV3 Approximate Interval Between Onset and Death Physician con /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown δ 23e. Did tobacco use contribute to the cause of death? Part II. Dthen significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No To the Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) 25 ဥ 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel [1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1x144312001 S. CLILITOKIST 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 0 1 2005

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	ryland / D	epart Certif	ment of H	ealth a Death	nd M		giene Reg. No.	005	18310
	Physici /Medio		1. Decedent's Name (First, Middle, Las GLADYS L. KIR							2. Date of De		2005 ^{ear}	3. Time of Death 2:30 p. M
	Examin		4a. Facility Name (If not institution, give MORNINGSIDE HOUSE	street and number) OF FRIEND	SHIP	41	b. City, Town, or HANOV		Death			County of Death NE ARUN	DEL
	Funeral Director		213-20-0113	x 7. Age ☐ M 2☐ X 88	(In yrs, last birt		f Under 1 Year Ionths Days	If Under 2 Hours	Min.	8. Date of Bird (Month, Da 6/5/	19 1 6	9. Birthp Cou MA	place (State or Foreign ntry) RYLAND
	show	or	Usual Residence of Decedent 10a. State 10b. County MD BALTIMO	RE	10c. City, Town	or Locati							10d. Inside City Limits 1 ☐ Yes 2X☐ No
	with tha N a or 28a-1 be rotiff	Direct	10e. Street and Number 8626 BLACK OAK R				10f. Zip Code 2 1 23	4				en of What Cou	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or Items 23e or 28e-f show aumatic event, the Medical Examinational be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		If Ye	s Decedent of Hi es, specify Cuba Yes 2 X No	spanic Orig	in? (Spe Puerto F	cify Yes or No Rican, etc.)		4. Race - Americ Black, White, Specify: WH.	
21215-0036	within 72 hou iene. 'then "nature ite Medical E	Completed	15. Decedent's El (Specify only highest grad Flementary/Secondary (0-12)	ucation		Decedent (Give kind life. DO	t's Usual Occupa d of work done o NOT use retired, TARY	ation fu <i>ring</i> most)	of workin	g		d of Business/In	·
ਰ		To Be C	17. Father's Name (First, Middle, Last) ELMER LOVING							(First, Middle,		Su <i>тате)</i>	
Mary	ind 2 shou alth and N 27 Is mar or traumal		19a. Informant's Name/Relationship (7 JOSEPH BAKER, JR.									Town, State, Zip MD 2063!	
altimore,	permit. Pages 1 and 2 should be Department of Health and Monta Important: If item 27 Is marked any injury or other traumatic e 200.		20a. Method of Disposition 1 🕅 Burial 2 Cremation 3 C 4 Donation 5 Other (Specify		20b. Place of MORELA		on (Name of EMORIAL	e)PK.	6/1/0	25 25		ation - City or To ENDALE,	
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Licenter (1997)	Huy	,		ame and Addres					UNERAL MD 2128	HOME P.A.
8760,	The law requires that the death certificate be exacuted make the has been signed by the attending physician and make page 2 should be detached for use as the burial-transit	ilcai Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	consequence of	of):	1Cer						Interval Between Onset and Death
P.O. Box 6	at the death certifica by the attending phateched for use as ti	Physician/Med	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	Fetal death		topic pregnancy ther (specify)				2:	3d. Date of delive Month	ery Day Year
	quires that n signed build be deta	by	Part II, Other significant conditions co	ntributing to death bu	t not resulting in	the under	rlying cause give	en in Part I.			obacco us		ne cause of death?
al Records,	rsicien: The law require s certificate has been sig firector, page 2 should b	Completed	25. Was case referred to medical							1 Yes	rmed? 2 di No	24b. Were auto prior to co death? 1 \(\subseteq \text{Yes}	psy findings available impletion of cause of 2 No
ot Vital	Physicien this certinal director	: To Be	examiner?	Hospital: 1 Inpatier			3 DOA Othe	or: 4 Nur	sing Hom	(Check only only only only only only only only	dence 6	Other (Specif	y)
Division of	or Attending Physicien: after death. Director: After this certifici in by the funeral director.	Certification;	1 Natural 5 Pending investigation 3 Suicide 4 Homicide 5 Could not be determined	28a. Date of Injun (Month, Day) 28e. Place of Inju building, etc	ry - At home, far	njury	M 1 □ Y	k?` Yes 2 □ N	lo		Street and		ul Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one) Certifying Physical Example (Check only one)	/sician: To the best o iner: On the basis of and manner stat	examination and	, death oc	curred at the tim tigation, in my op	e, date and pinion, death	place, a	nd due to the d at the time,	cause(s) a date and p	and manner as s place, and due to	tated. the cause(s)
	To the within To the compl	Me	29b. Signature and tiple of pertitler	5 1	MD		29c. License	number 047	0			signed (Month,	Day, Year)
	0		30. Name and address of person who of SRIDHAR ATLURI M		ath (Item 23a) (RTCHIE			NA, MI	21	122			
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 1 2005	69	r's Signature	rech							

DHMH 17 Rev 1/2001

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

			State of Maryland / Department of Health and M 1- State Registrar Certificate of Death		ene 0 0 5	8312
I	Physici		1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		Joyce Ann Leach 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	May .	4c. County of Death	3.00 /
	LAGIIIII		Union Memorial Hospital Baltimore		n/a	
I	Funeral Director		5. Social Security Number 2 16 - 74 - 1820 6. Sex 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Min.	8. Date of Birth (Month, Day, 1	Year) Coul	olace (State or Foreign ntry) ginia
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			Od. Inside City Limits
	Maryl -f sho lied a	tor	Md n/a Baltimore			1 Yes 2 No
	n the	irec	MIC n/a Baltimore 10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cou	ntry?
	23a c	al D	3001 McElderry Street 21205		USA	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinet must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 1 Never Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Bla	
Maryland 21215-0036	nin 72 ho n "natur	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working if the DO NOT use retired)	ing	6b. Kind of Business/In	dustry
212	od within giene. er than "	Com	10th Homemaker		Domesti	С
nd	be filed tal Hygi d other evant, I	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name Management			
yla	should be and Mental s markad o umatic eva	P _L	James Parker Margare			
Mai	nd 2 sh lth and 27 Is n traun		19a. Informant's Name/Relationship (Type, Print) John H. Leach/Husband 3001 McFlderry Str			
	theal		20a. Method of Disposition 20b. Place of Disposition (Name of	Date 2	Oc. Location - City or To	own, State
Baltimore,	Pages nent of I ant: If its ary or o		1) Sourial 2 Cremation 3 Removal from State King Memorial Park 6/4	/05 W	landlaws	MH
alti	permit. Departmimportaims any inju		21. Signature Funeral Second Licensee 22. Name and Address of Facility W y	lie F/H	of Balto	o. Co.
	89589		1000 Liberty Roa	d, Rand	lallstown	Md 21133
			234. Part1. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.	or respiratory arres	st,	Approximate interval Between Onset and Death
	Fnysician / /Medical		Immediate Cause (Final disease or condition resulting in death)			5 years
	Examiner		Due to (or as a consequence of):			·
	120	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):			
/	cate be executed physician and the burial-transit	Examiner	that initiated events c			
ó,	ate be executed hysician and the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):			
8760,	cate b	dicai	d			
.O. Box 6	that the death certific ed by the attending p detached for use as	by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown		23d. Date of delive Month	ery Day Year
S, D	S L 9		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to to	
of Vital Record	w require been sign	Completed		24a. Was an	24b. Were auto	psy findings available
Re	e fa has je 2	duic		autopsy perform	prior to co	mpletion of cause of
ta	(0 ==	a	25. Was case referred to medical 26. Place of Death			2 No
Ž	S 0 0	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hor	me 5 Residen	nce 6 Other (Specia	y)
	ding h. After fune		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury 28b. Time of Injury Work? Month, Day Year) 28b. Time of Injury 2 Work? M 1 Yes 2 No	28d. Describe how	v injury occurred	
Division	spital or Attano ours after death saral Diractor; filled in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,
	Hos Fur ely	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	and due to the cau red at the time, dat	use(s) and manner as s te and place, and due to	tated. o the cause(s)
	To the within 2 To the complet	W	29b. Signature and title of certifier 29c. License number		d. Date signed (Month,	
7	B		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			-i/ • _/
			Christopher Herleson 201 East University Richard Balt 31. Date filed (Month 1997) 1 2005 32. Egistrar's Signature	IMORE, M	() 212/8	
	Sta Registr		31. Date filed (Month) 1 2005 32. Agistrar's Signature			

				epartment of Health and Mental Hygiene Certificate of Death Beg. No. 2						
	Physici /Medic		1. Decedent's Name (First, Middle, Last) LEE WASHINGTON LEWIS	2. Date of Death A Year May 29, 2005 7:48 PM						
	Examir		4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birth)	4b. City, Town, or Location of Death Laurel 4c. County of Death Prince George's day) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign)						
	Funeral Director		231-14-1320 XXM 2□F 92 Y	day) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. JAN 14, 1913 9. Birthplace (State or Foreign Country) VA						
	ryland how		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town							
	the Ma	ecto	VA NOTTOWAY BLAC	KSTONE 10f. Zip Code 10g. Citizen of What Country?						
	3a or	ā	810 LUKE STREET	00001						
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Everting Items I ke inclified at ODGE.	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2774No If Yes, Give Married Year or Dates:	23824 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes Yes, No Specify: USA 14. Race - American Indian, Black, White, etc. Specify: BLACK						
Maryland 21215-0036	vithlo 72 ho ne. han "natu e Medical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation Give kind of work done during most of working ife. DO NOT use retired) 16b. Kind of Business/Industry						
р О	filed v Hygie other t		7 17. Father's Name (First, Middle, Last)	SECURITY OFFICER RAILWAY COMPANY 18. Mother's Name (First, Middle, Maiden Sumame)						
ylan	should be and Mental marked o	To Be	SOLOMON W. LEWIS	VIRGINIA						
Mar	d 2 sho th and 7 Is mu traum			Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O LUKE ST., BLACKSTONE, VA 23824						
	is 1 and of Health item 27 other to		20a. Method of Disposition 20b. Place of	isposition (Name of Date 20c. Location - City or Town, State crematory or other place)						
altimore,	Pages Iment of lant: If it		'4 □ Donation 5 □ Other (Specify) CREST	VIEW MEM. PK 06/02/2005 SOUTH HILL, VA						
Ball	permit. Departr Importa		21. Signavre of Funeral Service Licensee	22. Name and Address of Facility AMES A. MORTON & SONS F.H., INC 1701 LAURENS STREET, BALTO., MD 21217						
	Physician		23a. Part. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	t enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death						
	/Medical Examiner	_	Due to (or as a consequence of	risalony distress.						
	outed Id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	mental Status						
8760,	cate be executed physician and the burial-transit	dical Exa	resulting in death) Last Due to (or as a consequence of d. Occept B	acterio.						
O. Box 6	ath certifi ttending or use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 23d. Date of delivery 5 ☐ Other (specify) Month Day Year						
rds, P.	quires that the de n signed by the a uld be detached f	ed by Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown						
Records,		Complete	Renal Insufficie	24a. Was an autopsy findings available prior to completion of cause of death? 1 □ Yes 2₺□No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2₺□No						
Vital	sicien: The certificate hir	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one) Other: A Divising Home 5 Decidence 5 Double (Secrify)						
Division of	ding Phys h. After this funeral di	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1								
DIVIS	To the Hospitel or Attending Physicien: white 24 hours after death. To the Funeral Director, After this certification plately filled in by the funeral director,	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	a, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	To the Hospitel within 24 hours a To the Funeral Completely filled	edical ((Check only 2 Medical Examiner: On the basis of examination and	death occurred at the time, date and place, and due to the cause(s) and manner as stated. or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)						
	To th To th	M	29b. Signature and fittle of certifier	29c. License number 29d. Date signed (Month, Day, Year)						
6	*		30. Name and address of person who completed cause of death (Item 23a) (TSURESH K, KHETAN, MD: 7610	TOPE PRINT) CARROLL AVE # 260, TAKOMA PARKE MD						
	Sta Registr	te	31. Date filed (Month, Day, Year) 1 2005 32. Registrar's Signature	29d. Date signed (Month, Day, Year) D 55403 5130105 (PB. Print) CAFROLL AVE # 260, TAKOMA PARK MD 20912						

			Tor State Registrar	State	of Marylan	d / Depa	artment	t of Health e of Deat	and Me		giene Beg. No.	05	18314
	Physicia		1. Decedent's Name (First, Middle Robert Liebli							2. Date of Dea Month May 13	Day	Year	3. Time of Death 5:00 PM M
	/Medic Examin		4a. Facility Name (If not institution,		ımber)		4b. City,	Town, or Location		114) 15		nty of Deat	
	LXamiii		Holy Cross Nu	rsing & 1	Rehab		Bur	tonsvil	1e		Mon	tgome	ry
	Funeral			6. Sex	7. Age (In yrs. I	ast birthday)	If Under Months	1 Year If Under	er 24 Hrs. 8	8. Date of Birth (Month, Day	h /. Year)	9. Birt	hplace (State or Foreign
	Director		132-16-4927	1 🕅 M 2 🗆 F	77	Yrs.	1,011,01	,0		Oct 29,	1927		w York
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or La	cation						10d. Inside City Limits
	Maryl f sho	ō	MD Montg	Omerv	R	urtons	ville						1 ☐ Yes 2√2 No
	28a	rec	10e. Street and Number	omery		ar comb	10f. Zip	Code			10g. Citizen o	of What Co	untry?
	38 o	ai D	3412 Green Ca	stle Road	1			208	366		Ţ	JSA	
	deat	Funerai Director	11. Marital Status	12. Was Dec	cedent Ever in U.	S. 13.	Vas Deced	ent of Hispanic C	Origin? (Spec	city Yes or No-	14. R	ace - Ame lack, White	rican Indian,
0	or its		1 Never Married 2 Marri	ed 1 🖸 Yes If Yes, G Year or I	2 No		1 ☐ Yes 2				Spec		hite
0500-C	hours tural',	ed by	3 Widowed 4 Divorced		Dates:	162 Dogg	dont's Llous	I Occupation					
6 5	in 72 " na" r	Completed	(Specify only highes	t grade completed		(Give	kind of wor DO NOT us	rk done during m se retired)	ost of working	g	16b. Kind of	Dusiness	industry
7	i with jiene. r thar	E	Elementary/Secondary (0-12)	College 4	(1-4or 5+)	DC	lice	officer			law e	nforc	ement
2	othe vant,	Вес	17. Father's Name (First, Middle, L	ast)						(First, Middle,	Maiden Sum	ame)	
yland	Ments Ments arked atic a	70 E	Irving Liebli	.ng				Sa	11y Hu	ssbaum			
Mar	2 sho		19a. Informant's Name/Relationsh				-	(Street and Num			-		
ָ ע	l and Health Im 27 Ihar tu		Anna Liebling/s	pouse	20h P	341Z lace of Dispo		Castle	Road		20c. Location		20866
	Pages ent of t nt: If ite ry or of		1 ☐ Burial 2 ☐ Cremation '4 ☒ Donation 5 ☐ Other (Sc			emetery, crer	natory or of	ther place)			ZOC. LOCATION	ii - Oity oi	TOWN, State
Dallimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 21 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic avant, the Maulical Exerciting matter mailted at once.		21 Signature of Euneral Service L	censee	Director			d Address of Fac Anatomy ore, MD	Board 21201		Balti	more	Street
ı			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the death						rest,		Approximate Interval Between
F	hysician		Immediate Cause (Final disease or condition		umon	Sa							Onset and Death
	/Medical Examiner		resulting in death)		(or as a consequ								
ľ	=xamme	_	Sequentially list conditions,	b	ofor as a consequence	sole	15001	5					
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequ	dence or):							
•	akecu al-tra	xar	that initiated events resulfing in death) Last	c. Due to	(or as a consequ	uence of):							
, 0/0	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai I		d									
0	rtifical ng ph as th		IF FEMALE:										
200	ith ce tendii or use	ician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐Live	ufcome of pregna birth 2 ☐ Fetal	death 3	Ectopic pre	egnancy				Date of deli	very Day Year
5	the all	hysici	1 Yes 2 No	4□Preg 9□ Unki	nant at time of de nown	eath 5□	Other (spe	ecify)				violiti)	Day
Ţ.	that the	0	Part II. Dther significant conditio	ns contributing to	death buf not rest	ulting in the u	nderlying ca	ause given in Par	rt I.	23e. Did to	bacco use co	onfribute to	the cause of death?
necords,	uires sign ld be	d by	cerebrovas	sivlar	accid	ent				1 🗆 Y	es 2 🗹 No	3 🗆 Pr	obably 4 Unknown
Ö	w req s beer shou	iete								24a. Was a	an 24t	o. Were au	topsy findings available
ב ב	: The law cate has t page 2 s	ompleted								autop: perfor	med?	prior to death?	completion of cause of
VII S	an: rtifica tor, p	Se C	25. Was case referred to medical					26. Pla	ace of Death	(Check only or	-	1 103	20110
> i	nysic nis ce direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1	Inpatient 2	ER/Outpatier	it 3□ DO	A Other: 4	Nursing Hom	e 5 🗆 Resid	ence 6 🗆 C	ther (Spec	cify)
	ding Physician: The h. After this certificate funeral director, pag	on:	27. Manner of Death 1 Z Natural 5 ☐ Pending	28a. Date (Mo.	of Injury nth, Day Year)	28b. Time of Injury		8c. Injury af Work?		8d. Describe h	ow injury occ	urred	
IVISION	tend Jeath tor: / the fi	icat	2 Accident investig	ot be	o of laive. At he		M .	1 Yes 2		Of Location /S	troot and Num	mbor or Pr	ral Route Number,
<u> </u>	after after Dirac	ertification:	4 Homicide determi	ned 286. Place	e of Injury - Af ho ding, efc. <i>(Specif</i>)	me, ram, su /)	eet, ractory	, опісе	20	City or Tow		noer or Au	nar Houle Number,
	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifica completely filled in by the funeral director,	edical C	29a. Certifier (Check only one) 1 Certifying 2 Medical S	g Physician: To th Examiner: On the and ma	ne best of my kno basis of examina nner stated.	wledge, death	n occurred a vestigation,	at the time, date in my opinion, d	and place, ar	nd due to the d d at the time, d	cause(s) and date and place	manner as e, and due	stated. to the cause(s)
	Vithir Comp	Me	29b. Signature and tifle of certifier	- A	0 0		29c	. License numbe	ər	2	29d. Date sign	ned (Month	n, Day, Year)
			Mary	a Na	lelma	euh,	MM.	D 253	48		5/2	16/0.	5
			30. Name and address of person of Marcia Gold	who completed car	use of death (Item 15020 6	23a) (Type, hady	Grov.	eRd Ro	ockvil	le, md	20	850	
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 1 2	005	Registrar's Signa	ture	Les of						

ADH UNKNOWN 05-3258 Michael E. Larsen

Па	er c. r	als		ryland / Depa	artment of F			ene g. No. 005	133	15
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death	0, 2005 ear	3. Time of De	
	/Media	al	Michael E. Larsen 4a. Facility Name (If not institution, give street and number)		4h City Town o	r Location of Death	LIAI T	4c. County of Death		Рм
	Examir	ier	DOCTORS HOSPITAL	the state of the s	LANHAM			PRINCE GE	ORGES	
L	Funeral Director		1 \	(In yrs. last birthday) 81 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,) Aug 15,	(ear) 9. Birth Co.	place (State or F intry) U1	nk nk
	land ow	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City	Limits
	ith the Marylar or 28e-f show	to	MD Prince George's	Hyatts	ville				1 ☐ Yes 2	№ No
	h with the 23a or 28 81 be not	Funeral Director	10e. Street and Number 4903 Cherokee Street		10f. Zip Code	20781	100	g. Citizen of What Cou	intry?	unk
	r deat	ner	11. Marital Status 12. Was Decedent E Armed Forces?		Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White		
9000	ours afte rel', or l	b	1 Never Married 2 Married 1 Yes 2 N If Yes, Give Year or Dates:		1 ☐ Yes 2 🏹 No	Specify:		Specify: wh		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then *neturel', or Items 23a or 28e-1 show importent: If item 27 is marked other then *neturel', or Items 23a or 28e-1 show principly or other treumatic event, the Medical Examble must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unk College (1-4or 5-	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of worki	ng unk 16	6b. Kind of Business/li	ndustry	unk
	e filed al Hygid other vent,	BeC	17. Father's Name (First, Middle, Last)	'		18. Mother's Name	(First, Middle, Ma	aiden Sumame)		
ylaı	should be find Mental hind marked of	To	Misha Pocnekoff			Dora Ske				
Maryland	12 sho h and 7 is ma treum		19a. Informant's Name/Relationship (Type, Print) Linda Larsen/former spouse	19b. Maili	ng Address (Street	and Number or Rura	ul Route Number, (City or Town, State, Zi	p Code)	unk
	Pages 1 and nent of Health ont: If item 27 ury or other tr		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, crea	osition (Name of matory or other place		Date 20	Oc. Location - City or T	own, State	
Baltimore,	permit. Pag Department Importent: I eny injury o		`4 □Donation 5 ₩ Other (Specify) in state 21. Single of Funeral Service Licensee Conald S. Wade Dire	ctor S	2. Name and Addre	omy Board	655 W.	Baltimore	Street	
			23a. Part1 Enter the disease, or complications that caused	the death. Do not ent	altimore, er the mode of dyin			it,	Approximate Interval Between	
	Physician /Medical			bive whe	rosclerat	ic Gardion	asculer	disose	Onset and Dea	ath
h	Examiner		O	consequence of):						
	pe isi	niner		consequence of):						
68760,	eath certificate be executed attending physician and for use as the burial-transit	ical Examiner	that initiated events c.	consequence of):						
68	rtificate ng phy as the	Aedic	U. TERMANE							
P.O. Box	The law requires that the death certificate be executed at the seen signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)	/		23d. Date of delive Month	rery Day Yea	ar
	res that the de signed by the a be detached f	by Pr	Part II. Other significant conditions contributing to death but	t not resulting in the u	inderlying cause giv	ren in Part I.	23e. Did toba	cco use contribute to	the cause of dea	ith?
ord	w require been sig should b	ted t	hed and neck injuries				1 🗆 Yes	2 □ No 3 □ Pro	bably 4 Unk	(nown
I Records,	The law rate has be page 2 sh	Completed					24a. Was an autopsy performe	prior to co	opsy findings ava empletion of caus 2 No	
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		Oth	ar.	(Check only one)			1
of	ding Physicien: The in the intermental After this certificate hat funeral director, page	7: To	1 X Yes 2 No 1 Inpatier 27. Manner of Death 1 Natural 5 Pending 4. Month, Day		nt 3□ DOA 28c. Injur Wor	4 LI Nursing Ho	me 5 🗌 Residen 28d. Describe how	ce 6 □Other (Speci rinjury occurred	fy)	
ion	Attending Is death. ector: After by the funer	atlor	2-Accident investigation 5-10-0	5 13:0		rk? Yes 2 X No	Subject	ettell		
Division	i ji ji	Certification:	3 Suicide 6 Could not be determined 28e. Place of Inju building, etc	ry - At home, farm, st. . (Specify)	A COURSE		28f. Location (Stre Chr or Town, B. L. Moe	et and Number or Rui State)	al Route Number	ivet-
	To the Hospitel or Attend within 24 hours after death To the Funerel Director; completely filled in by the	Medical (29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of 2 ☑ Medical Examiner: On the basis of and manner sits	examination and/or in						
	To the To the comp	Me	29b. Signature and title of certifier	Rone	29c. Licens OCME	e number		d. Date signed (Month)		
			30. Name and address of person who completed cause of de	path (Item 23a) (Type,	Print) 111 P	enn Stree		more, Mary		201
	Sta	ate	2.2	r's Signature	G.					
4	Regist	rar	JUNO 1 ZUUD Reference	U. APORAL	1					

		ľ	For State Registrar	State of Ma	aryland		artment <i>tificate</i>					giene Reg. No	UUU	18316	
			Decedent's Name (First, Middle, La	st)							2. Date of Dea	ıth		3. Time of Death	_
	Physici /Medio		PHILIP P. LANA	A, SR.							Month MAY	26°,	2005	10:33 A.M	1
	Examin		4a. Facility Name (If not institution, giv				4b. City, To	own, or	Location	of Death		4c.	County of Deat		
			GOOD SAMARITAN HO						ORE C				N/A		
	Funeral Director		220 0) 2194		e (In yrs. 18 83	ast birthday). Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day 9/1/19	, Year) 21	9. Birtl Co MAR	nplace (State or Foreign untry) YLAND	n
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits	_
	Maryl f sho	ior	MD N/A		BAL	TIMOR	E CITY	7						1 XYes 2 No	
	286	Director	10e. Street and Number				10f. Zip C	Code				10g. Cit	izen of What Co	untry?	_
	h with	J D	1801 LYDONLEA WA	Y			21	1239				U	SA		
	deat	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S	6. 13. V	Vas Decede	nt of His	spanic Ori	igin? (Spe	cify Yes or No- Rican, etc.)		14. Race - Ame		_
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. In marked other then "natural", or Itams 23a or 28e-1 show aumetic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 【 Married 3 ☐ Widowed 4 ☐ Divorced	1 AYes 2 N If Yes, Give Year or Dates:	o WWII		☐ Yes 2[Specify:		iloan, etc.,		Specify: WH		
2	72 ho natur ilcal	eted	15. Decedent's Ed (Specify only highest gra			16a. Deced	ent's Usual	Occupa	ition	t of workir	ng	16b. K	ind of Business/l	ndustry	
21215-0036	d within jiene. r than "	Completed	Elementary/Secondary (0-12) 12TH GRADE	College (1-4or 5	+)		kind of work OO NOT use FTSMAN					GLE	N L. MAH	RTIN	
Maryland 2	be d la la la la la la la la la la la la la	Be	17. Father's Name (First, Middle, Last, CARMELLO LANA		,						(First, Middle, RBUSCA	Maiden	Sumame)		
2	s 1 and 2 should file the strain and Men It Health and Men Item 27 ie marka othar traumatic	은	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	a Address /	Street a	nd Numbe	er or Bura	Boute Numbe	r City o	r Town, State, Z	in Code)	
	and 2 seath ar n 27 le lar trau		DOLORES LANA/WIFE				LYDONL				IMORE,		21239	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
re,	es 1 and of Health filtem 27 r othar tr	1	20a. Method of Disposition			ace of Dispo:	sition (Name	of of	1				ocation - City or	Fown, State	
Ë	Pages nent of int: If It		1 A Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specif		DULA	NEY T	ARDENS	MEM	" i	5/31	/2005	COC	KEYSVILI	E. MD	
Baltimore,	permit. Pages Department of Important: If It any injury or o		21. Signatury of Funeral Service Licer	see the			Name and			ty THE	JOHNSO	V FU	MERAL H	OME, P.A. 286	_
			23a Part1. Enter the disease, or com	plications that caused	the death									Approximate	
	Enysician		shock, or heart failure. List only Immediate Cause (Final disease or condition			0)	1	15					Interval Between Onset and Death	
	/Medical		resulting in death)	a Due to (or as a	a consequ	ence of:	cvaus	4 -	Ma	nte	nr_				
	Examiner		Sequentially list conditions,	b. A	SCI	15	104	7			12270		Earth		
	pe ii	iner	any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	uppence s	enes of): /	0	-							
_	and I-trans	Examin	that initiated events resulting in death) Last	c. Due to (or as a	ent	ence of):	rype	vu.	usi	ñ					_
8760,	cate be executed physician and the burial-transit	al E		. 0,		to a	2010.7	1101-)					
687	ficate p phys	edical		d	work	20 //	-	res	***						_
). Box	it the death certifii by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetel	death 3	Ectopic preg Other (spec					2	23d. Date of deli Month	very Day Year	
о. О	d by t		9 ☐ Unknown Part II. Other significant conditions of		it not room	ting is the up	dorbing on.		n in Doet I		22a Did to	22222	sa agatributa ta	the cause of death?	
ecords,	law requires that the as been signed by th 2 should be detache	ed by		ontributing to death bu		unig in the di	- Idenying cau	ıza ğıva	min rani.	•		es 2[
ပ္ပ	law re as be 2 sho	ompleted									24a. Was a		24b. Were aut	opsy findings available ompletion of cause of	
T,	The ate h page	Com									perfor	ned? 2 V No	death?		
Vital	cian: ertific actor,	Be (25. Was case referred to medical examiner?			-			-	of Death	(Check only on	~			
-	y sign	<u>٩</u>	1 ☐ Yes 2 KNo	Hospital: 1 Inpatier		R/Outpatient		_	4 LI NU				3 □Other (Spec	ify)	
00	nding F ath. r: After e funera	atlon:	27. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day		28b. Time of Injury	280 M	c. Injury Work' 1 🗆 Y	at ? es 2⊡		8d. Describe h	ow injun	y occurred		
DIVISION	l or Atte after des Diracto	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At hor . (Specify)	ne, farm, stre	et, factory, o	office		2	8f. Location (Si City or Town			ral Route Number,	1
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ledical C	29a. Certifier (Check only one)	ysician: To the best on the basis of and manner sta	examinati	rledge, death on and/or inv	occurred at estigation, in	the time	e, date an inion, dea	d place, a	nd due to the cad at the time, d	ause(s) ate and	and manner as place, and due	stated. to the cause(s)	112
	To the within To the comple	Med	29b. Signature and title of certifier				29c. l	License	number		2	9d. Date	e signed (Month	Day, Year)	_
			Frenkl	Salmini	ا د	nw	>	20	94	75		03	5/26/6	35	
	5+1		FRANK S. PA	completed cause of de	J7	2 MM	srint)	72.	24	ARFZ	ANRO.	13	Altimo	se, MD.	
	Sta Registr	-	31. Date filed (Month, Day, Year) JUN 0 1 2	32. Registra	r's Signati	ire	est o								
				The state of the s	Car Car	A. 11 11 11 11 11 11 11 11 11 11 11 11 11	J. C. C. C. C. C. C. C. C. C. C. C. C. C.								_

DHMH 17 Rev 1/2001

			For	State of Marylar	nd / Departme	ent of Health and I	Mental Hyg	giene o o o	4 9
		•	1 - State Registrar		•	ate of Death		Reg. No. 4 UUD	18317
	Physicia	an	Decedent's Name (First, Middle, La	st)	- 1 '		2. Date of Dea Month		3. Time of Death
	/Medic	al .	Clizaber	h C. 14a	CHI	. Town out continued Death	MAY	Day Year 2 8 2005	11225 P.M
	Examin	er	4a. Facility Name (If not institution, giv	e street and number)	11.1	ty, Town, or Location of Deatl		CO CCO	n
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.	last birthday) If Und	er TYear If Under 24 Hrs.	8. Date of Birth	9. Birt	hplace (State or Foreign untry)
	Director		ary au abug	□M 2 F	Yrs. Moriti	s Days Hours Mill.	9-26		RYLAND
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Location				10d. Inside City Limits
	Mary I-f sh	tor	MD Carro	110	Wos	t minste	1		1 Yes 2 No
	ith the	Oirec	10e. Street and Number	1.5	10f.	Zip Code		10g. Citizen of What Co	untry?
	s 23a	Funeral Director	131 Coral	Ct.	10 10 110 110	31151		USH	deen Indian
	after des	Fune	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 Tyes 2 M No	If Yes, s	cedent of Hispanic Origin? (S pecify Cuban, Mexican, Puerl	o Rican, etc.)	14. Race - Ame Black, Whit	
200	ral', or	by	3 Widowed 4 Divorced	1 ☐ Yes 2 1 No If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify: W	hite.
215-0036	be filed within 72 hours after death with the Maryland Hygiene. do ther then "natural", or items 23a or 28a-f show avent, if a Medical Eracili at must be ricitified at	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Decedent's U (Give kind of life. DO NO	work done during most of wo	king	16b. Kind of Business/	Industry
7	filed withir Hygiene. Ither then	duc	Elementary/Secondary (0-12)	Callege (1-4or 5+)	Telenh	no Open	70/	B+O BA	Urand.
פר	e filed of Hyg other vent,	BeC	17. Father's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·	18. Mother's Nar	ne (First, Middle,	Maiden Sumame)	CTT COXCT
<u>ya</u>	should be filed within nd Mental Hygiene. I marked other then umatic event, the Market was the M	10	John K. Ca	24		Lare	tta S	nyder	
	12 sho h and 7 is m traum		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Addre	ess (Street and Number or Ru	_ 1	r, Citylor Town, State, 2	Zip Code)
	s 1 and 3 of Health item 27 other tra		20a. Method of Disposition	20b.	Place of Disposition (I	lame of	Date	20c. Location - City or	Town, State
altimore,	2 = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special		cemetery, crematory of	18841R	31-05	Forest /	HIL MAD
a	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice	2588	22. Name	and Address of Facility		E, MO 21	
n	205 20		Muly C	1. SWIDTHY	EVAN	FUNERAL CH	MEL. OF	800 HHILFC	RORD. Approximate
			23a. Part 1. Enter the disease, ir comshock, or heart failure. Let only Immediate Cause (Final	17.10	(-		or respiratory an	rest,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	aDue to (or as a conse		holism			1 morth
	Examiner		Sequentially list conditions,	40 .1	ionk Lu	ng Nodnie			(mone
	Sit 9d	iner	cause. Enter Underlying	Due to (or as a conse	quence of):				
	axecut	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conse	quence of);				
/60	The law requires that the death certificate be executed tto has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	calE		_ d					
99	artifica ing ph e as th		IF FEMALE:			0.57%			
Rox	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of	al death 3 Ectopic			23d. Date of del Month	ivery Day Year
o.	at the de by the a tached	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	00201 3 0010	(Specily)			
ດົ	res that igned to be deta	by Pi	Part II. Other significant conditions	contributing to death but not re	sulting in the underlyin	g cause given in Part I.		obacco use contribute to	
ecords,	w require been si should b						1 🗆 Y	'es 2 No 3 Pr	obably 4Unknown
Hec	The law cate has b page 2 st	Completed					24a. Was a autop perfor	sy prior to	stopsy findings available completion of cause of
		e Co	25. Was case referred to medical			26 Place of Do	1 ☐ Yes	2☐No 1☐Yes	2 - No
5	ysician: is certific director,	To B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	☐ER/Outpatient 3☐	04	,	lence 6 Other (Spe	cify)
0	ding Phys h. After this tuneral di		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		ow injury occurred	
<u>S</u>	Vttendi death. ctor: A y the t	icatl	2 Accident investigation	e Con Class of Injury At h	M	1 Yes 2 No	38f Location (S	Street and Number or Ri	uni Pouta Number
Division of	after a Direc	Certification:	4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	ify)	ory, office	City or Tow		irai noute ivuniber,
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Pl	nysician: To the best of my kn miner: On the basis of examin	owiedge, death occum	ed at the time, date and place	e, and due to the d	cause(s) and manner as	stated.
	To the H within 24 To the Fo complete	Medical	one)	and manner stated.	_				
	or Z	~	29b. Signature and title of certifier	MO		D 52035	4	29d. Date signed (Mont	31 2005
	10		30. Name and address of person who	completed cause of death (Ite	orn 23a) (Type, Print)			44	<u> </u>
	V		BINU CHAGO	291 Stune	Avenie	D 52035 Westm	nista	MD 2119	+
	Sta Registr		31. Date filed (Month, Day, Year)	0 1 200 Sgistran Sign	ature Jo				

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2005 /Medical 4a. Facility Name (If not institution, give street and nymber) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMO PO or 1 Year | If Under 24 Hrs. 5. Social Security Number Maven DALMMOKE ocn If Under 1 Year Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 M 2 □ F Hours Months 220-36-517. Usual Residence of Decedent Director 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show other traumatic event, the Modical Exercites must be notified at 1 ☐ Yes 2 ☐ €0 **Funeral Director** 10W30N BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 21204 or itams 23a Odd Was Decedent Ever in U.S. Armed Forces? 140 Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. 11. Marital Status Black, White, etc. filad within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 3 No f Yes, Give Year or Dates: Specify: Specify: Completed by 3 Widowed 4 Divorced White "netural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 18 permit. Pagas 1 and 2 should be fila Department of Health and Mental Hy, Important: If item 27 is marked other eny injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Morgan Milton Margare 19a. Informant's Name/Relationship pe, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) n u20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) Garden 22. Name and Address of Facility 21. Signature Funeral Service Licensee EVANS FUNERAL CHAPEL 880 UHAR mD 212 FORDRO 10 23a. Part 1. Enter the disease, or complications that payed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician NEUMONIA 2 WEEKS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law raquires that the death certificate be executed Due to (or as a consequence of): attending physician P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) ad by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? baen signad of Vital Records, CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔭 Onknown Be Completed ATRIAL FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an certificata has autopsy performe 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 XNo Certification: To this 28a. Date of Injury (Month, Day Year) in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After or Attending 5 Pending investigation 1- Natural Injury 1 🗌 Yes 2 🗌 No death. 2 Accident 3 🗌 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funarel L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00061765 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILKENS 女てつみ AVE BALTIMORE MUD 21229 Ü 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Blown & Spark Registrar

DHMH 17 Rev 1/2001

DSEPH

ORIGINAL

			1 - Stata Registrar	State of Ma	aryland / Depa	artment of F			the say of the	8319
			Hegistrar Decedent's Name (First, Middle, Last)			tinoate of	Deatif	2. Date of Dea	Rag. No.	3. Time of Death
	Physici /Medic		Monroe Mullin	iх				May	2 3 2 2 0	65 4:05 Рм
	Examin		4a. Facility Name (If not institution, give s Frederick Mem		ospital	4b. City, Town, o Frede	r Location of Death		4c. County of De	
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	(, Year) (irthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	WI ZUF	81 Yrs.			May 23	,1924 Mar	yland
	yland yland		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	e-fst	ctor	Maryland Frederic	k	F	rederick				1 ☐ Yes 2 ² No
	ith the	DIre	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	s 23e	rall	6200 Glen Valley			2170			U.S.A.	
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentalle Hyglene. Important: If tiern 27 is marked other than "neturel", or Items 23e or 28e-f show many injury or other treumatic event. I'th Medical Exarchete must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	2. Was Decedent I Armed Forces? 1 X Yes 2 □ N If Yes, Give	lo	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🎞 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, Wh	nerican Indian, hite, etc. Vhite
3	ture!		15. Decedent's Educ	Year or Dates:		dent's Usual Occup	ation		16b. Kind of Busines	
2	hin 72 9. 9n "ne	Completed	(Specify only highest grade	completed) College (1-4or 5	(Give	kind of work done DO NOT use retired	durina most of work	ing		a
7	ed wit	Com		1+		eeper/Acc			Manufactu	ring
2	be file ital Hy doth event	Be	17. Father's Name (First, Middle, Last)						Maiden Surname)	
y a	hould d Men marke matic	2	Monroe Noll Mulli 19a. Informant's Name/Relationship (Ty)		10h Mailie	a Address (Street	Pauline			Ti- Codel
<u> </u>	nd 2 s Ith an 27 Is r treur			Sister)		-			r, City or Town, State, Baltimore,	
נֿע	s 1 ar		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	20b. Place of Dispo	The state of the s		Date	20c. Location - City of	
2	Page nent o int: If		1 ☐ Burial 2 ☑ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Balto/Was		1	-2005	Laurel, M	laryland
Dallillo	permit. Departn Importe any inju		21. Signature of Funeral Service License	106	W. 1	Name and Addre	ss of Facility eral Home	of Cat	onsville,	Inc.
T			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused	the death. Do not ent	er the mode of dyir	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between
	Pnysician	F 53	Immediate Cause (Final disease or condition	COF	K					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					7
	_xummer	7	Sequentially list conditions, if any, leading to immediate	Due to (or as:	a consequence of):					
/	uted J ansit	Examiner	cause. Enter Underlying	200 10 (0) 40						
Ś	an and rial-tra	Еха	that initiated events cresulting in death) Last	Due to (or as	a consequence of):			_		
,	cate be executed physician and the burial-transit	dlcal	d							
9	entifica ling pl	0	IF FEMALE:		-4					
2	uires that the death certific signed by the attending p d be detached for use as	Physician/M	in the past 12 months?	3c. If yes, outcome 1□Live birth 4□Pregnant at	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
;	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	unio di dodini 30	Other (specify)				
_	s that ned b e deta	by Pł	Part II. Other significant conditions con	tributing to death bu	at not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ž	w require been sig should b							1X Y	es 2□No 3□F	Probably 4 Unknown
ָ נ	law reas be	Completed						24a. Was a autops		autopsy findings available completion of cause of
_	: The cate h	Con						perform	med? death? 2X No 1 ☐ Ye	
) 	ician certifi ector	Be	25. Was case referred to medical examiner?	ospital:	V	Oth	26. Place of Deat			
5	Phys r this ral dii	1: To	1 Yes 2 No	1 Inpatie	/	I 3 DOA	4 Nursing Ho		ence 6 Other (Sp ow injury occurred	ecify)
5	nding tth. r: Afte e fune	atlor	1 Natural 5 Pending investigation	(Month, Day	Year) Injury	Wor	k? Yes 2 □ No		,	
2	r Atte er dez rectoi by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju-	ry - At home, farm, str	eet, factory, office		28f. Location (St City or Town	treet and Number or F	Rural Route Number,
5	ital or re aft rel Di									
	To the Hospital or Attending Physician: The law requires that the death certify that hours after death. To the Furentel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier Cartifying Phys (Check only one) Madical Examin	ician: To the best of ar: On the basis of and manner sta	of my knowledge, death examination and/or in	n occurred at the time vestigation, in my o	ne, date and place, pinion, death occurr	and due to the cared at the time, d	ause(s) and manner a ate and place, and du	is stated. le to the cause(s)
	o the	Med	29b. Signature and title of certifier	and mariner sta	1802	29c. Licens	e number	2	9d. Date signed (Mor	nth, Day, Year)
	- S - O		X 1/1/8	aufnar	~	D-1	3971		5/26/0	5
	{\		30) Name and address of person who co	npleted cause of de	eath (Item 23a) (Type.	Print)	21(1) 1	A	1	in Milal
	·		Kobert	& ald Ir	nann	[Kt(tt)	LILK /	ulthior	1al tu	SUITAL
	Sta Registr		31. Date filed (Manifil Ally, Mean 201	Dedistra	ir's Sign Afre	HEL!				
	i legisti	-	1		•					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ician		me (First, Middle, Last)	N TO TO			Health an Beath	2. Date of Month	Da		3. Time of Death
dical	JOSE								005	8:00 P
niner		(If not institution, give s				or Location of D	Death	40	o. County of Deat	h
	5. Social Security	aw Place Ap		n yrs. last birtho	Baltime		Hrs. 8. Date of	Birth		hplace (State or Foreig
al or	227-44-	1792 🔀	Хм 2□ F 67	7′ _{Yr}	Months Days	Hours N	Min. 01/10	71938	B VIRG	TNIA
	10a. State	10b. County	10	Oc. City, Town	or Location					10d. Inside City Limit
tor	MD	N/A		BALT	IMORE CITY	7				1X Yes 2 □ N
Olrec	10e. Street and N				10f. Zip Code	_		10g. Ci	itizen of What Co	ountry?
la I	1701 EU	TAW PLACE A			21217				USA	
once. To Be Completed by Funeral Director		rried 2 Married 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates:	er in U.S.	13. Was Decedent of If Yes, specify Cu		? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ame Black, White BL Specify:	
ted	(Spe	15. Decedent's Educe	cation campleted)		ecedent's Usual Occi		f working	16b. h	Kind of Business/	Industry
nple	Elementary/Sec		College (1-4or 5+)		ife. DO NOT use retir	ed)	J	нарі	BOR CITY	BAKERY
Completed				DA	KER	18 Matharia	Name (First, Mid			. DIMILICI
To Be		e (First, Middle, Last) H • MEADE				ETHE	EL L. JON	VES		
		Name/Relationship (Type SINSON / SIS			Mailing Address (Stree 3 NORFOLK					
	20a. Method of Di			20b. Place of D	Disposition (Name of crematory or other pi	(ace)	Date	20c. L	ocation - City or	Town, State
		2 ☐ Cremation 3 ☐R n 5 ☐ Other (Specify)	lemoval from State	MT. ZI	ON CÉMETÉ	RY 6/	/3/05	BA	LTIMORE	CO., MD
, ,	21. Signature of	ral Service License	ee 🗸		22. Name and Add	ress of Facility	HOWELL E	UNER	AL HOME	
once	1 //	/ When	1	elva	4600 LTB	ERTY HE	GHTS AVE	E. BA	LTIMORE,	MD 21207
an al er	Immediate Lause diseas Condit resulting in death	tion n)	Atheroscle Due to (or as a c	erotic (t enter the mode of dy	ring, such as ca	rdiac or respirator			Approximate Interval Between Onset and Death
al er je	Immediate Zause diseas of condit resulting in death	conditions, immediate driving or injury nots	Atheroscle	erotic (consequence of	t enter the mode of dy Cardiovasc):	ring, such as ca	rdiac or respirator			Approximate Interval Between
al Examiner	snow, or set immediate aussidiseas conditions and conditions are set in the conditions are set i	conditions, immediate driving or injury nots	Atheroscle Due to (or as a c	erotic (consequence of	t enter the mode of dy Cardiovasc):	ring, such as ca	rdiac or respirator			Approximate Interval Between
a a saminer stan/Medical Examiner	snow, or set immediate aussidiseas conditions and conditions are set in the conditions are set i	ent pregnant 12 months?	Atheroscle Due to (or as a c	consequence of conseq	t enter the mode of dy Cardiovasc):	ving, such as ca	rdiac or respirator		23d. Date of del Month	Approximate Interval Between Onset and Death
ு ந் by Physician/Medical Examiner	Short, or relimined to australiant to australiant in death Sequentially list of any, leading to australiant in the cash that initiated ever resulting in death IF FEMALE: 23b. Was deceded in the past of a superior australiant in the superior australiant in the superior australiant in the superior australiant in the superior australiant in the superior australiant in the superior australiant in the superior australiant in the superior australiant in the superior australiant in the superior australiant in the superior aus	ent pregnant 12 months?	Due to (or as a complete to the control of the cont	consequence of conseq	t enter the mode of dy Cardiovasc):): 3 □ Ectopic pregnar 5 □ Other (specify)	ving, such as ca ular Di	rdiac or respirator SCASC	y arrest,	23d. Date of del Month	Approximate Interval Between Onset and Death
ு ந் by Physician/Medical Examiner	Short, or relimined to australiant to australiant in death Sequentially list of any, leading to australiant in the cash that initiated ever resulting in death IF FEMALE: 23b. Was deceded in the past of a superior australiant in the superior australiant in the superior australiant in the superior australiant in the superior australiant in the superior australiant in the superior australiant in the superior australiant in the superior australiant in the superior australiant in the superior australiant in the superior aus	eart rawlie. List only or e (Final tion n) conditions, immediate or injury nts n) Last ent pregnant 12 months? 2 □ No wn	Due to (or as a complete to the control of the cont	consequence of conseq	t enter the mode of dy Cardiovasc):): 3 □ Ectopic pregnar 5 □ Other (specify)	ving, such as ca ular Di	rdiac or respirator SCASC	y arrest,	23d. Date of del Month	Approximate Interval Between Onset and Death livery Day Year o the cause of death?
নু ত্ৰ npleted by Physician/Medical Examiner	Short, or relimined to australiant to australiant in death Sequentially list of any, leading to australiant in the cash that initiated ever resulting in death IF FEMALE: 23b. Was deceded in the past of a superior australiant in the superior australiant in the superior australiant in the superior australiant in the superior australiant in the superior australiant in the superior australiant in the superior australiant in the superior australiant in the superior australiant in the superior australiant in the superior aus	eart rawlie. List only or e (Final tion n) conditions, immediate or injury nts n) Last ent pregnant 12 months? 2 □ No wn	Due to (or as a complete to the control of the cont	consequence of conseq	t enter the mode of dy Cardiovasc):): 3 □ Ectopic pregnar 5 □ Other (specify)	ving, such as ca ular Di	23e. D 1 24a. W	y arrest, id tobacco ☐ Yes 2 Fas an utopsy	23d. Date of del Month use contribute to 2 \(\text{No} \) 3 \(\text{Pr} \) Pr 24b. Were at prior to death?	Approximate Interval Between Onset and Death Onset and Death
নু ত্ৰ npleted by Physician/Medical Examiner	snc. k, or self immediate austration in death Sequentially list of any, leading to cause (Disease that initiated ever resulting in death IF FEMALE: 23b. Was deceded in the past 1 1 Yes 2 9 Unknow Part II. Other sign	ent pregnant 12 months? 2 No	Due to (or as a complete to the control of the cont	consequence of conseq	t enter the mode of dy Cardiovasc):): 3 □ Ectopic pregnar 5 □ Other (specify)	ular Di	23e. D 24a. W a p 1 □ Yes	id tobacco ☐ Yes As an utopsy utopsy size of the si	23d. Date of del Month use contribute to 2 \(\text{No} \) 3 \(\text{Pr} \) Pr 24b. Were at prior to death?	Approximate Interval Between Onset and Death livery Day Year or the cause of death? robably 4 Minnov
নু ত্ৰ npleted by Physician/Medical Examiner	Immediate aussidiseas condil resulting in death Sequentially list of if any, leading to cause (Disease that initiated ever resulting in death IF FEMALE: 23b. Was deceded in the past 1 Yes 2 9 □ Unknow Part II. Other sign	ent pregnant 12 months? 2 \(\sum No \) wn nifficant conditions conditions conditions, immediate or injury nts 12 months? 2 \(\sum No \) wn	Due to (or as a complete by the course of th	consequence of conseq	t enter the mode of dy Cardiovasc : 3	ular Di	23e. D 24a. W a p 1 □ Ye f Death (Check or	id tobacco Yes 2 As an utopsy erformed? is 28 N	23d. Date of del Month use contribute to 2 No 3 Pr 24b. Were au prior to death? 1 Yes	Approximate Interval Between Onset and Death Onset and Death
ন চ চ Completed by Physician/Medical Examiner	Short, or he Immediate austideas conditresulting in death Sequentially list of any, leading to the Immediate Characteristics of the	ent pregnant 12 months? 2 No wn Inificant conditions conditions in the state of the	Due to (or as a complete by the course of each limit. Due to (or as a complete by the course of the	erotic consequence of	Cardiovasc Cardio	ular Di	23e. D 24a. W a p 1 Y colored to the colored to t	id tobacco Yes 2 As an utopsy erformed? s 28 N	23d. Date of del Month use contribute to 2 No 3 Pr 24b. Were au prior to death? 1 Yes	Approximate Interval Between Onset and Death Onset and Death Death Day Year Day Year Death Cause of death?
ন চ চ Completed by Physician/Medical Examiner	Short, or he Immediate austideas conditresulting in death Sequentially list of any, leading to the Immediate Characteristics of the	eart rawure. List only or e (Final tion n) conditions, immediate or injury nts n) Last ent pregnant 12 months? 2 □ No wn nificant conditions	Due to (or as a complete by the course on each line. Atheroscle Due to (or as a complete by the course of the cou	pregnancy Fetal death not resulting in t	Cardiovasc Cardio	ular Di	23e. D 24a. W a p 1 Ye f Death (Check or ing Home 5 R 28d. Description	y arrest, y arrest,	23d. Date of del Month Duse contribute to 2 No 3 Pr 24b. Were au prior to death? 1 Yes 6 Other (Speury occurred	Approximate Interval Between Onset and Death Onset and Death Death Day Year Day Year Day Application of Cause of the Cause
ন চ চ Completed by Physician/Medical Examiner	Immediate aussidiseas of condiferentially list of any, leading to cause (Disease that initiated ever resulting in death IF FEMALE: 23b. Was deceded in the past 1 1 Yes 2 9 Unknow Part II. Other sign 25. Was case refexaminer? 1 Yes 2 27. Manner of De 1 Yes 1 20 Accident 3 Suicide 4 Homicide	ent pregnant 12 months? 2 No wificant conditions conditions inition 15 Pending investigation 6 Could not be electrifying Physical	Due to (or as a complete by the course of each limit. Due to (or as a complete by the course of each limit.)	pregnancy Fetal death not resulting in to the consequence of the conse	cardiovasc Cardio	ular Did	23e. D 24a. W a place, and due to	id tobacco Yes As an utoposy erformed? ss Noty one) desidence be how injute the Cause(23d. Date of del Month use contribute to 2 \(\text{No} \) 3 \(\text{Pr} \) Pr 24b. Were au prior to odeath? 1 \(\text{Yes} \) Yes 6\(\text{Cher} \) (Speury occurred	Approximate Interval Between Onset and Death Onset and Death
ন চ চ Completed by Physician/Medical Examiner	In FEMALE: 23b. Was deceded in the past 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ent pregnant 12 months? 2 No wificant conditions conditions inition 15 Pending investigation 6 Could not be electrifying Physical	Due to (or as a compute to	pregnancy Fetal death not resulting in to the consequence of the conse	cardiovasc Cardio	given in Part I. 26. Place of Other: 4 \(\text{Nursitions of the Part I)} \(\text{Nursitions of the Part I)} \(\text{Nursitions of the Part I)} \(\text{Nursitions of the Part I)} \(\text{Nursitions of the Part I)} \(\text{Nursitions of the Part I)} \(\text{Nursitions of the Part I)} \(\text{Nursitions of the Part I)} \(\text{Nursitions of the Part I)} \)	23e. D 24a. W a place, and due to	id tobacco Yes 2 As an utopsy erformed? sis 2 Noty one) tesidence be how injuined for (Street a Town, Statuther Cause), and the cause (me, date an 29d. D	23d. Date of del Month Duse contribute to 2 No 3 Pr 24b. Were au prior to death? 1 Yes 6 Cther (Speury occurred and Number or Rife) s) and manner as and place, and due late signed (Mont)	Approximate Interval Between Onset and Death Onset and Death
e টি Certification; To Be Completed by Physician/Medical Examiner	In FEMALE: 23b. Was decede in the past 1 1 1 Yes 2 9 1 Unknow Part II. Other sign 25. Was case ref examiner? 1 1 Yes 2 2 27. Manner of De 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ent pregnant 12 months? 2 \(\sum \) No with the prediction of the pregnant of the pregnant of the pregnant of the prediction of the predi	Due to (or as a complete cause on each line. Atheroscle Due to (or as a complete cause of complete cause of complete cause of complete cause of complete cause of complete cause of complete cause of ca	pregnancy Fetal death not resulting in to the consequence of the conse	cardiovasc Cardio	ular Di.	23e. D 24a. W a place, and due to	id tobacco Yes 2 As an utopsy erformed? sis 2 Noty one) tesidence be how injuined for (Street a Town, Statuther Cause), and the cause (me, date an 29d. D	23d. Date of del Month Duse contribute to 2 No 3 Pr 24b. Were au prior to death? 1 Yes State Other (Speury occurred	Approximate Interval Between Onset and Death Onset and Death

DHMH 17 Rev 1/2001

		i icus	State of Ma							lental Hv		.cgibic	•	
	-	For State Registrar	Otate of Me	ai y tai t	-	rtificate				_	Reg. No.	00	5 1	8321
		Decedent's Name (First, Middle, I	Last)	-						2. Date of De	ath			Time of Death
Physicia		William	Kenny r	nes:	Soria					Month	Day 27	30G	ir 5 -	7:26 PM
/Medio Examin		4a. Facility Name (If not institution, s					Town, or	Location of	of Death)	4c. 0	ounty of D	eath	
		Harbor Ho	Spital Ce	nte			Dal.	timi	ے.			~/	A	
Funeral			1011 105		ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Feb. 14	th ^{y,} Year) 1 0 3 0	9.1	Birthplace Country)	(State or Foreign Lrginia
Director		212-36-2018 Usual Residence of Decedent	X	67	110.					reb.14	,1939	we	SL VI	паппа
yland 10w		10a. State 10b. County		10c. City	, Town or Lo	cation								nside City Limits
Mar-s-	to	Maryland n/a		I	Baltim	ore							1	TYes 2□No
ith the	Oire	10e. Street and Number				10f. Zip					_	en of What		
be filed within 72 hours after death with the Maryland be filed within 72 hours after death with the Maryland by the well by then "ratural", or items 23a or 28a-f show do other than "natural", or items 23a or 28a-f show event. It whe like I be in clifted at	Funeral Director	3963 Brooklyn Av		_			2122					ted S		
er de Items	nue	11. Marital Status 1 Never Married 2 Married	12. Was Decedent I Armed Forces?		S. 13.	Was Deced If Yes, spec	lent of Hi of Cuba	ispanic Ori n, Mexicar	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	- 1	4. Race - A Black, W		ndian,
Irs aft	by F	3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 1 1 If Yes, Give Year or Dates:	10		1 ☐ Yes 2	XX	Specify:				Specify:	White	9
2 hou		15. Decedent's	Education		16a. Dece	dent's Usua kind of wor	i Occupa	ation	et of work	ina	16b. Kin	d of Busine	ss/Industr	у
thin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5	i+)	life.	DO NOT us	e retired))	t of work	ng				
ygien ygien it, I'k	So	12 years			Bake	<u>r</u>		40 M-45	ada Nasa	(Cinch Adiabata	BAke			
be fill half H ad oth	Be	17. Father's Name (First, Middle, La	,				1			e (First, Middle, a Crites		sumame)		
hould d Med mark matic	2	William Messoria 19a. Informant's Name/Relationship			19b. Mailir	na Address	(Street a	`		al Route Numbe		Town. Stat	a. Zip Cod	(e)
IVICA Ind 2 s Ith an 27 is r treu			wife)							cimore,			2122	-
s 1 ar f Hea item othe		20a. Method of Disposition	_	20b. P	lace of Dispo emetery, crer	sition (Nan	ne of ther plac	e)		Date	20c. Loc	ation - City	or Town,	State
Page nert o nert or ry or		1 ABurial 2 ☐ Cremation 3 1 4 ☐ Donation 5 ☐ Other (Spe			ar Hil				5-1-2	2005	Broo	k1yn	Park,	, MD
perfullibition of the filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Hygiene.		21. Signature of Funeral Service Lie	- Andrews - Control of the Control o	-	. A	2. Name an	d Addres	s of Facili	ak Fu	ineral I	Home,	P.A.		
n goesa			J. WAyne Os		riig 1	30 E.	For	t Ave	e. Da	altimore	e, ML	2	1230	
		23a. P. m1. Enter the disease, in contact, or heart failure. Lis or	omplications that caused by one cause on each lin	the death	n. Do not ent	ter the mode	e of dyin	g, such as	cardiac	or respiratory a	rrest,		Inte Ons	proximate erval Between set and Death
Physician /Medical		Immediate Cont Final disease or condition resulting in death)			cardi	OMY	opent	hy					me	who
Examiner			Due to (or as		uence of):	0		10					0.45	2-
	ig	Sequentially list conditions, if any saving to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to lor as		uence of):	Teci IO	v~						Une	day
cuted d ansit	Examiner	Cause (Disease or injury that initiated events	, hupu	rkal	Gardi.								en	e day
f oo, te be executed ysician and te burial-transit	Exe	resulting in death) Last	Due to (*r as	a consequ	uence of):									J
of o	dicai		d		·····									- 22
A 00 sertifica ding ph	/Me	IF FEMALE:	23c. If yes, outcome	of pregna	ncv						0	3d. Date of	dolinon	
atten for us	Physician/Med	23b. Was decedent pregnant in the past 12 movins?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3[Ectopic pro					2.	Month	Day	Year
the d by the ached	nysi	1 Yes 2 No 9 Unknown	9☐ Unknown											
s that	by P	Part II. Other significant condition	s contributing to death b	ut not resu	ulting in the u	inderlying c	ause give	en in Part I	١.	23e. Did t	obacco us	e contribut	e to the ca	use of death?
equire en sig		chronic obstruct	rie pulmo.	rary	disec	ase,	syst.	olic		10'	Yes 2	No 3 €	Probably	4 □Unknown
law requires t as been signe	Completed	heart failure	CERCHARY	a	rtery	dis	in S	<u>u</u>		24a. Was	osv	Drior	to complet	indings available tion of cause of
The The page	Con		1		,					1 Tyes	rmed? 2 No	death 1 🗆 Y		No
VICAL Ician: 1 Sertificat ector, p	Be	25. Was case referred to medical examiner?	Hospital:				Oth			h (Check only o				
Physic this or	<u>은</u>	1 Yes 2 Mo	1 (2) Inpatie		ER/Outpatier 28b. Time o		Bc. Injun	v at		me 5 🗆 Resi			Specify)	
ding th. After	tion	1 Natural 5 Pending 2 Accident investiga	(Month, Da	y Year)	Injury	M	8c. Injun Worl	k? Yes 2□			,			
r Attending for death. Irector: After by the fune	ifica	3 ☐ Suicide 6 ☐ Could no determin	ot be 28e. Place of Injury	ury - At ho	ome, farm, str	reet, factory	, office			28f. Location (. City or To		Number o	Rural Roi	ute Number,
tai or s afte el Dir	Certification:	4 Hornicide	building, et	с. (Зресп)	// 					- City of Tol	wii, Siale)			
To the Hospital or Attanding Phyalcian: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicai	(Check only 2 Medical Ex	Physician: To the best xaminer: On the basis of	f examinat	wledge, deat tion and/or in	h occurred vestigation,	at the tin	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) a date and	and manne place, and	as stated	cause(s)
thin 2 the on the omplet	Med	29b. Signature and title of certifier	and manner sta	ated.		290	. Licens	e number			29d. Date	signed (M	onth, Day,	Year)
F 18 F 00		Ain L	. 0											
1		30. Name and address of person w	ho completed cause of c	leath (Item	1 23a) (Type,	Print)	1			more, n	1-12	7 00	100	
1		Lisa Wenzel	3001	Sou	th H	anove	- Sh	reet,	Bult	more, 1	Naryle	ind o	2123	S
Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	ture	down!	20	1						
Regist	rar	JUN V	T Ends	Page 100	80 P	5						_ .		

			1 - For State Registrar	State of Mary		artment of H			giene Reg. No:)5	183	22
ı	Physici	an	Decedent's Name (First, Middle, Last Maxxx	J.	Моа	dows		2. Date of De. Month	Dav	Year	3. Time of	
	/Medic	cal	Mary 4a. Facility Name (If not institution, give		Mea	4b. City, Town, or	Location of I	May	29, 20		6:25	Рм
	Examir	ier	8213 Edwill Avenue			Rosed				timor	e	
	Funeral		5. Social Security Number 6. Se	7. Age (Ir	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bird Min. (Month, Da	h v Yearl	9. Birth	place (State o ntry)	r Foreign
L	Director		212-60-3261]M 21X F	53 Yrs.	Months Days	Hours	Min. (Month, Da January	0,1952	MD.	y)	
	and w		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ocation					10d. Inside Ci	ty Limits
	Maryl 1 sho	to	MD Baltimo	re	Ro	sedale					1 🗆 Yes	2X No
	ith the Marylan or 28a-1 show	irec	10e. Street and Number	·····		10f. Zip Code			10g. Citizen of	What Cou	ntry?	
	23e c	a D	8213 Edwill Avenue	2		21237	7		USA			
36	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortent: If item 27 is marked other then "naturel", or Items 23e or 28e-1 show injury or other treumatic event, the Medical Exell fact mat must be notified at e.g	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Evel Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:			ispanic Origir n, Mexican, F Specify:	n? (Specify Yes or No Puerto Rican, etc.)	14. Rad Bla Specif	ck, White,		
21215-0036	2 hou	ted	15. Decedent's Edu			dent's Usual Occupa		ddeina	16b. Kind of B			
21,5	ithin 7 le. len "r	Completed	(Specify only highest grad	College (1-4or 5+)	life. I	kind of work done of DO NOT use retired)	or working				
	filed within Hygiene. other then "		9 years		Ma	chine Ope			Poly S		brp.	
Maryland	ild be fi lental H ked ot ic ever	To Be	17. Father's Name (First, Middle, Last) Eugene Gross					s Name <i>(First, Middle,</i> y Hoover	Maiden Sumar	ne)		
ary	2 should and Men Is marke eumatic	1	19a. Informant's Name/Relationship (7)	rpe, Print)	19b. Mailir	ng Address (Street a	and Number	or Rural Route Numbe	ar, City or Town	State, Zip	Code)	
	es 1 and 2 of Health a f item 27 ls r other trei		Ronald Meadows	Husband			Avenue	, Rosedale				
Baltimore,	Pages 1 nent of H ant: If iten		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Camoual from State		sition (Name of matory or other place Faith Cerret		June 1, 2005	20c. Location Roseda			
Balt	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funecal Service Licens	Enne	lly 3	Name and Address Connelly I 7110 Solle	s of Facility Funera ers Po	l Home Of int Road,	Dundalk Dundalk	, P.A.	21222	2
	Physician /Medical Examiner		23a. Part1. Enter the disease or compishock, or heart failure. Ust only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the ne cause on each line. a	itic 9	er the mode of dying		ardiac or respiratory ar	rest,	-	Approximate Interval Bety Onset and D	ween Death
8760,	icate be executed physician and s the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co								
.O. Box 6	The law requires that the death certificate be executed tte has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)				te of delive	,	/ear
rds, P.	quires that an signed b	by	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the u	nderlying cause give	en in Part I.		obacco use cont es 2 □ No	ribute to ti 3 ☐ Prob	w /	eath? Jnknown
Record		Completed						24a. Was autop perfor 1 Yes	med?	Were auto prior to co death? 1 Yes	psy findings a mpletion of ca 2 No	available ause of
Vita	icien certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		Othe		f Death (Check only o				
Division of	Attending Physicien: r death. sctor: After this certific. by the funeral director.	ation: To	1 Yes 2 No ' 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatien 28b. Time of Injury	28c. Injury Work	er: 4 Nursi at (? Yes 2 No	28d. Describe h	ence 6 □Oth ow injury occur		(y)	
Divis	lel or Attending s after death. Bl Director: After ed in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, str Specify)	eet, factory, office		28f. Location (S City or Tow	treet and Numb n, State)	er or Rura	al Route Numb	ber,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical (29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of m ner: On the basis of exa and manner stated.	y knowledge, death umination and/or inv	occurred at the tim vestigation, in my op	e, date and pointion, death	place, and due to the o occurred at the time, o	cause(s) and ma date and place,	inner as s and due to	tated. the cause(s)	
	To the within 2 To the complet	7	29b. Signature and title of certifier			29c. License			29d. Date signe			
,	A		1 Jahr	•			7484	/	5/31/	00		
	01	19	30. Name and address of person who co									
			Dr. Ashkan Bahran: 31. Date filed (Month, Day, Year)		dpiper Ci	rcle, Whi	te Mar	rsh 21236				
:-	Sta Registr		JUN 0 1 200	5 Maries	Signature App	de						

		-	State Unpend Item 23a,	te of Maryland / De 27,28 a-f per m e	partment of Health e <i>fthteate of Deal</i>	h and Me tas		ene 2005	18323
	Physici	an	1. Decedent's Name (First, Middle, Last) Sofia Isabel	1-	Miller		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al -					May 29,	2005 4c. County of Death	7:21 a. [™]
4	Examin	er	4a. Facility Name (If not institution, give street a Johns Hopkins Bayviet		4b. City, Town, or Location Baltimore			4c. County of Deatr	1
	Funeral	-	5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	y) If Under 1 Year If Und	der 24 Hrs. g	3. Date of Birth (Month, Day, Y	9. Birth	nplace (State or Foreign
	Director		212-73-2496 ^{1□ M 2}	Yrs.	Months Days Hour 28		May 1,20	05 MD.	•
)	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f ehow any injury or other traumatic event, if a Medical Exercities could be notified at once.	to	MD. Baltimore	Dunda	1k				1 ☐ Yes 2X No
336		al Director	10e. Street and Number 1902 Stanhope Road		10f. Zip Code 21222		100	, Citizen of What Co USA	untry?
		by Funeral	1X Never Married 2 Married 1 If Y	is Decedent Ever in U.S. ned Forces?]Yes 2X1 No 'es, Give ar or Dates:	3. Was Decedent of Hispanic If Yes, specify Cuban, Mexi 1 Yes 2 No Spec	ican, Puerto Hi	ify Yes or No- ican, etc.)	14. Race - Amer Black, White Specify: W	
21215-0036		Completed		oleted) (Gi	cedent's Usual Occupation ve kind of work done during n DO NOT use retired)	most of working	7	Sb. Kind of Business/I	ndustry
d 2			N/A 17. Father's Name (First, Middle, Last)		N/A 18. Mo	other's Name (First, Middle, Ma		
lan'		To Be	Justin John Miller		Le	slie Ma	ae Delci	d	
Maryland			19a. Informant's Name/Relationship (Type, Pri	•	ailing Address (Street and Nur				ip Code)
			Justin & Leslie Mille 20a, Method of Disposition	20b. Place of Dis	2 Stanhope Ro	Dau Da		c. Location - City or	Town, State
mor			1 XBurial 2 ☐ Cremation 3 ☐ Remova 1 4 ☐ Donation 5 ☐ Other (Specify)	al from State	rematory or other place) art Of Jesus Cem.	June 2.	2005 Di	undalk,MD.	
Baltimore,			21. Signature of Funeral Service Licensee	h	22. Name and Address of Fa Connelly Fune 7110 Sollers	acility eral Hon	ne Of Du	ndalk,P.A.	21222
			23a. Part1. Enjer the disease, or complication shock, or heart failure. List only one cause	s that caused the death. Do not a se on each line.					Approximate interval Between
	Pnysician		Immediate Cause (Final disease or condition resulting in death) Sudden Unexplained Death in Infancy(SUDI)						
-	/Medical Examiner			Oue to (or as a consequence of):					
	cate be executed physician and the burial-transit	Examiner	cause. Enter Underlying	Due to (or as a consequence of):					
			Cause (Disease or injury that initiated events c.	Due to (or as a consequence of):	isequence of):				
8760,		dlcal E	d	20.000000000000000000000000000000000000					
9	tificate ig phy as the	ledic							
.O. Box	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	Physiclan/Me	in the past 12 months?		3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of deli Month	very Day Year
<u>α</u>		To Be Completed by	Part II. Other significant conditions contributi	ng to death but not resulting in the	underlying cause given in Pa	art I.	23e. Did toba	cco use contribute to	the cause of death?
Records,							24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of
Vital			25. Was case referred to medical examiner?			lace of Death ((Check only one)		
of			Yes 2 No Hospita 27. Manner of Death 28a	i. Date of Injury 28b. Time	of 28c, Injury at	-	e 5 🗌 Residen	ce 6 Other (Spec	unk
ion			1 □Natural 5 □ Pending F 2 □ Accident investigation 5	ound Pay Year Foun -29-05 6:59	Work?	X No			
Division		Certification:	4 Homicide	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		Du Du	28f. Location (Street and Number of Rural Route Number, City or Town, State) 1902 Stanhope Road Jundalk, Baltimore County, MD		
		Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	To the Within 2 To the comple	M	29b. Signature and title of certifier	MA	29c. License numb	per	290	I. Date signed (Month	
			1 WWW	8 VV	OCME			May 30, 2	2005
			30. Name and address of person who complete	AN	111 Penn S	treet	Baltimo	re, Maryla	and 21201
	Sta Regist		31. Date filed (Month, Day, Year) JUN 0 1	32. Registrar's gnature	& Sparker				

			1- For State of Maryland / Departm	nent of Health and Mental Hycate of Death	ygiene Reg. No. 005 18324				
	- · · ·		1. Decedent's Name (First, Middle, Last)	2. Date of D Month	Death 3. Time of Death				
	Physici /Medic		JOSEPH B. MARSHALL	MAY	26 2005 11:50 A M				
1	Examin	er		City, Town, or Location of Death	4c. County of Death				
				TAKOMA PARK Inder 1 Year If Under 24 Hrs. 8 Date of B	MONTGOMERY 9. Birthplace (State or Foreign				
	Funeral			Inder 1 Year If Under 24 Hrs. 8. Date of B (Month, D) No. 1 Year APRIL	Day, Year) 15 1937 MARYLAND				
	I within 72 hours after death with the Maryland interest in 1990. The Madical Examinat must be notified at 1990.		Usual Residence of Decedent	ALKIL	15 1557 HARTHAND				
		. [10a. State 10b. County 10c. City, Town or Location	1	10d. Inside City Limits				
		cto	MD PRINCE GEORGE'S CAPITOL F	HEIGHTS	1∭Yes 2 No				
		Dire		ff. Zip Code	10g. Citizen of What Country?				
		ral		20743	U.S.A. 14. Race - American Indian,				
		Funeral Director	1 Never Married 2/V Married 1 TYes 2 No.	Decedent of Hispanic Origin? (Specify Yes or N , specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.				
920		ğ	If Yes, Give 1 ☐ Y 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	es 212 No <i>Specify</i> :	Specify: BLACK				
21215-0036		Completed	15. Decedent's Education 16a. Decedent's (Specify only highest grade completed) (Give kind of Give Usual Occupation of work done during most of working	16b. Kind of Business/Industry					
21	within ene. than "	nple	Elementary/Secondary (0-12) College (1-4or 5+)	OT use retired)					
2			10th LABO	RER 18. Mother's Name (First, Middle)	GOVERNMENT				
anc	ntal Hed ot	Be	FRANCES MARSHALL	SARAH ELIZABE					
Maryland	should by nd Menta marked maric ay	ြ		dress (Street and Number or Rural Route Num					
8	nd 2 sho lith and 27 is mu				L HEIGHTS, MARYLAND 2074				
ē,	ges 1 and 2 should be filed it of Health and Mental Hyg If itam 27 is marked otha or other traumatic avant,		20a. Method of Disposition 20b. Place of Disposition cametery, crematory	(Name of Date	20c. Location - City or Town, State				
E	Pages nent of int: If it		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify) RIVERDALE C		RIVERDALE, MARYLAND				
Baltimore,	permit. Pages Department of Important: If i any injury or		21. Signature of Funeral Service Licensee 22. Nan	ne and Address of Facility J. B. JEN	NKINS FUNERAL HOME				
<u> </u>	Den Imp			4 LANDOVER ROAD LANDO					
y.			23a. Part1. Enter the disalise, or complications that caused the death. Do not enter the shock, or heart failure. In the disalise of the death.	mode of dying, such as cardiac or respiratory	arrest, Approximate Interval Between Onset and Death				
	Physician		Immediate Cause (Final disease or condition	ull sepsis	7 days				
	/Medical Examine phasician and phasician and the burial-transit		resulting in death) Due to (or as a consequence 1):	10 1 0 001	W				
		F .	Sequentially list conditions, if any leading to immediate b. Due to for as a consequence oil.	tonful cauc	er the				
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	31	V				
Ć		Exa	that initiated events resulting in death) Last c. Due to (or as a consequence of):						
8760,	ate be hysicia the bur	edical	d.						
9	ntifica ng ph s as th	Med	IF FEMALE:						
Box	eath certific attending pl for use as t	an/l	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ector	pic pregnancy	23d. Date of delivery Month Day Year				
0.	the a	Physician/M	1 Yes 2 No 4 Pregnant at time of death 5 Othe 9 Unknown	er (specify)					
Ф	The law requires that the death certific thas been signed by the attending page 2 should be detached for use as:		Part II. Other significant conditions contributing to death but not resulting in the underly	d tobacco use contribute to the cause of death?					
Vital Records,	sign d be	d by	Atrial Cibrollation	10	1 Yes 2 No 3 Peopably 4 Unknown				
50	w requir been si should I	ompleted		24a. Wa	as an 24b. Were autopsy findings available				
Re	The lav	шc		per	topsy prior to completion of cause of death?				
ta	CO LT	ပိ	25. Was case referred to medical	1 ☐ Yes 26. Place of Death (Check only					
<u>></u>		O.B	examiner?	Other	sidence 6 Other (Specify)				
Jof		n: T	27. Manner of Death 1 Deatural 5 Pending (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? 28d. Describe	28d. Describe how injury occurred				
<u>i</u>	att att	atic	2 Accident investigation M						
Division	or Atten after deat Diractor: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)		(Street and Number or Rural Route Number, own, State)				
	Hospital or 4 hours afte Funaral Dir tely filled in								
	To tha Hospital or Atti within 24 hours after de To tha Funaral Diracti completely filled in by ti	edical	29a. Certifier (Check only one) 2 ☐ Medical Examiner: On the bast of my knowledge, death occi (Check only one) 2 ☐ Medical Examiner: On the basis of examination and/or investig and manner stated.						
	To tha within 2 To tha complet	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)				
	- >F 0		Maddullelinger, HOSPITALICT	D52381	5/26/05				
	1)	+	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)						
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBYN D. ANDERSON 7000 (LAROLL AVE TAKONLA PARK WW 20012						
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's Signature									
	negisti	aı	T T T T T T T T T T T T T T T T T T T						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** May June Ε. Moore 30, 2005 11:15 a.m. /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Co. Parkville 1001 Walden Court | If Under 1 Year | If Under 24 Hrs. | B. Date of Birth (Month, Day, Year) | Min. | May 22, 1920 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Funeral 1□ M 2X F 85 Vrs Maryland 212-12-1679 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural" any linjury or other traumatic excellent any linjury or other traumatic excellent. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □ Yes 2 🛣 No Funerai Director Maryland Baltimore Co. Parkville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? United States 21234 1001 Walden Court 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No Specily: Specify: White Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cosmetology Beautician 8 yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Caldwell Elizabeth Kingsley Robert 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Mary V. Gambrill / Friend 205 E. Joppa Rd. Unit 2806 Towson, MD 21286 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 06/03/2005 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery Michael E. Canapp 22. Name and Address of Facility 21. Signature of Funeral S. 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Chronic Obstructive Pulmenory Disease Immediate Cause (Final disease or condition resulting in death) /Medical 10411 Examiner Due to (or as e consequence of). Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the buriel-trensit Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 5 tenos: 1 10411. Aprtic \$ 24b. Were eutopsy findings availeble prior to completion of cause of death? efter death. Director: After this certificate hes been sig d in by the funeral director, page 2 should t Be Completed 24a. Was en autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 1 No Medical Certification: To 28b. Time of 28d. Describe how injury occurred 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? 27. Manner of Death 1 Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Atte within 24 hours efter de To the Funerel Directo completely filled in by the 4 I Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature end title of certifier D30182 May 31, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Balhmore MD ZIZZV welthen 11.d billiam sussell me 200

32. Registrar's Signature

Delin H. Goods

DHMH 16 Rev 6/95

State

Registra

31. Date filed (Month, Day, Year)

JUN 0 1 2005

			Amend Item 24a per Verb., G844,06/01/050	ient of Healt July Late of Dea	th and Mo th	ental Hyg	jiene Reg. No. 20	05	183	126
	Physici	an	Decedent's Name (First, Middle, Last)			2. Dete of Dee Month	Day	Year	3. Time of De	eath
	/Medic		Joaquina V. McKinney	4h Cih	Town or Los	05 -19 cation of Deeth	- 2005 4c. County of	of Dooth	6:30 j	p.m.
J.	Examin	er	4a Fecility Neme (If not institution, give street end number) Heartland Health Care Center	1	lphi	ation of Deetin	Prince		cges	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If U	Inder 1 Year If Un		8. Date of Birtl (Month, Day		9. Birthpl	ace (State or F	-oreign
	Director		578-48-7653 1□ M 2\(\tilde{2}\tilde{1}	nths Days Hou	urs Min.	12-18-1	919	Cuba	ny)	
,	P .		Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location					10	od. Inside City I	Limits
	Aaryle f eho	ō	Maryland Prince Georges Adelphi						1X Yes 2	
	158 188 188 188	rect		f. Zip Code			10g. Citizen of W	hat Coun	try?	
	h with	ai Di	1801 Metzerott Road	20783			USA			
21215-0020	permit. Pagas 1 end 2 should be filed within 72 hours efter death with the Marylend Depertment of Heatth and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28e-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	1 □ Never Married 2 □ Married 1 □ Yes 2 【 No	Decedent of Hispanic, specify Cuben, Mexes 2 No Specify	c Origin? (Specifican, Puerto F		Black	- America c, White, c Blac	etc.	
2-0	72 ho	ğ	15. Decedent's Education 16a. Decedent's (Specify only highest grade completed) (Give kind of Give Usual Occupation	most of workin	na	16b. Kind of Bu				
121	ne ne ne ne ne ne ne ne ne ne ne ne ne n	Completed by	Elementary/Secondary (0-12) College (1-4or 5+)	of work done during i OT use retired)			Sibley M Hospita		laı	
р Б	Hygie Hygie Int, It	8	9th Dietic		fother's Name	(First, Middle,	Maiden Surname			
Maryland	d be sentel cove	To Be	Eleutrio Iznaga			a Valle		•		
ary	shou and M mari	-	19a. Informant's Name/Relationship (Type, Print)	drass (Street end Nu	umber or Rura	Route Numbe	r, City or Town,	State, Zip	Code)	
Σ	end 2 ealth an 27 is		Alicia I. Graham/ Niece Landover	ntral Hill r, Marylar	nd, 207					
Baltimore,	gas 1 t of H if Iten or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, crematory	y or other place)	į.	Date	20c. Location - (
틆	than tant:		4 Donation 5 Other (Specify) Chesapeake	Crematory ne and Address of Fe			Beltsv			
Ba	Depending of the policy of the			14th St.,					z, inc.	
15.	A SE		23a. Part1. Enter the disease, or complications that cau ed the death. To not enter the shock, or heart failure. List only one cause on each line.	mode of dying, such	h as cardiac o	r respiratory er	rest,	1	Approximate Interval Betwee Onset and Dea	en
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Cancer with Metastat Due to (or as a consequence		se			1	1 month	
	ted nsit	edical Examiner	b					1		
Ć,	icate be axecuted physician end s the buriel-transit	Exal	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	→ O1):				1		
68760,	te be iysicia ne bur	cai	that initiated events Due to (or as e consequence	of):						
_	artifica ing ph e es th		resulting in death) Last					1		
g B	ath ce	lan/	0.							
P.O. Box	he de / the e	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underly	ring cause given in P	Part I.		obacco use con			
	that the band by deta	by Pr				ישו	res 2□ No	3 Proc	ably 4∐Off	IKHOWH
Division of Vital Records,	The law requires that the deeth certificate be axecuted ate has been signed by the ettending physician end page 2 should be detached for use as the buriel-transit	Completed b	Dementia			24a. Was perfor	an autopsy med?	cor	ere autopsy find allable prior to appletion of cause death?	_
Be	The last age 2	E O	Pneumonia			101	es 2 No	1 🗆	Yes 2□ No	0
ita	lan: Triffica	Bec	25. Was case referred to medical examiner?	26. F	Place of Death	(Check only o	ne)			
<u></u>	Physician: r this certifica iral diractor,	မှု	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐				ence 6 □Othe	' ' ')	
ono	Attending P or deeth. ector: After t by the funare	ation:	27. Manner of Death 1 □Natural 5 □ Pending 2 □ Accident investigation 28a. Date of Injury (Month, Day Year) (Month, Day Year) M	28c. Injury at Work? I 1 ☐ Yes		28d. Describe r	ow injury occurre	9 d		
Divis	i or Attend after deeth Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, street	actory, office	2	8f. Location (S City or Tox	itreet and Numbern, State)	er or Aura	Route Numbe	э <i>г</i> ,
	To the Hospital or Attending Physician: The law within 24 hours after deeth. To the Funeral Director: After this certificate has completaly filled in by the funaral director, page 2	edicai C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occur on the basis of examination and/or investigand manner stated.	irrad at the time, dat ation, in my opinion,	te end place, a , death occurre	nd due to the o	cause(s) and mar date and place, a	nner as st ind due to	ated. the cause(s)	
	Vithir To th	W	29b. Signature engrittle of certifier	29c. License numb	ber		29d. Date signed	(Month,	Jay, Yeer)	
			P At Cul	D19609			May 20,	200	5	
			30. Name end addless of person who completed cause of deeth (Item 23e) (Type, Print) Dr. Raman R. Tuli	3503 Per Mount Ra				2		
	Sta Registr	1/2	31. Date filed (Month, Day, Year) 2005 P. Registrar's Signature							

			1 - For State Registrar	State of M	laryland / D	epartmer Certificat					giene Reg. No.	2005	5 18327
	Dhysisi		1. Decedent's Name (First, Middle	, Last)						2. Date of De Month	ath Day	Ye	3. Time of Death
	Physici /Medi		LOUIS	<u> </u>		ME	YERS			MAY 2	6, 20	005	6:45 A M
	Examir		4e. Fecility Name (If not institution	-		4b. City,	Town, or	Location			4c.	County of D	
			COLLINGSWOOD			hday) If Unde	1 Vaar	RO If Under	CKVIL				ITGOMERY
в	Funeral Director		5. Social Security Number 119–32–6539	6. Sex 7. A	ge (In yrs. last birt 93 `	Yrs. Months		Hours	Min.	8. Date of Bir (Month, Da MAR . 20	y, Year)	9.	Birthplace (State or Foreign Country)
			Usual Residence of Decedent							MAIX • 20	9 1 7 1 2	-	141
	nylan how		10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits
	Ba-f	cto	NH ROCI	KINGHAM	H/	AMPSTEAD							1 □ Yes 2 No
	vith th	Dire	10e. Street and Number	D04D		10f. Zig	Code	0384	/. 1		10g. Citi:	zen of What	
	s 23s	Frai	51 WASH POND	-	Francis II C	10 Mar Dave	d==4 =611°			-4. V N		14 Dans 4	USA
21215-0036	be filed within 72 hours after death with the Maryland nat Hygiene. Id other than "natural" or items 23a or 28a-f ehow event. I'm Medical Examinat must be rediffed at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 🂢 Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces ed 1 Tyes 2 M If Yes, Give Year or Dates:	? ! No	If Yes, spe		spanic Or n, Mexica Specify		ecify Yes or No Rican, etc.)		Black, W Specify:	merican Indian, hite, etc. WHITE
5-0	72 ho	sted	15. Decedent (Specify only highes		16a.	Decedent's Usu	al Occupa	ation	st of worki	ina	16b. Kir	nd of Busine	ss/Industry
2	C 08	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	(Give kind of wo	se retired,)		9	EDI	ICATIO	N.I.
12	filed with Hygiene other the		17. Father's Name (First, Middle, I	5+		reacher		10 Marth	ada Nama	(Cina Ministr		JCAT10	N
Maryland	should be filed withing Mental Hygiene. marked other than matic event, the M	Be c	JOSEPH	231/	GLANZE	- P			LONA	(First, Middle,	Maideri	Surname)	ROSENBUTH
Z		7	19a. Informant's Name/Relationsh	ip (Type, Print)		Mailing Address	(Street a			l Route Numbe	er. City or	Town, State	
Ž	nd 2 lith a 27 is		ELAINE STEINE	BERG / DAUGI		LFINEGA							
Je,	pes 1 and of Healt If item 2 or other		20a. Method of Disposition		20b. Place of	Disposition (Nai	ne of	- 1		ate	-		or Town, State
E	Page nent o int: If iry or		1 🔀 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		, ,	IDE CEM		i i	05/2	9/2005	SAD	DLEBRO	OOK, NJ
Baltimore,	permit. Pag Department Important: any injury o		21. Signatur Funeral Service L	icensee/		22. Name ar		s of Facili	ity SC	L LEVIN	NOSI	& BRO	S., INC. E, MD 21208
н	ă		23a. Part / Enter the disease, or shook, or heart failure. List of	complications that cause	d the death. Do n								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	2		ATION PN							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	s a consequence o	of):							
4	LAdminer	_	Sequentially list conditions,	b. ——————		STIVE HE	ART	FAIL	URE				
	pe tist	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a consequence o	ARY ARTE	ם עם:	TCEA	C E				
	ate be executed hysician and the burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as	a consequence of		. N I D	IJLA	JL				
8760,	siciar buris	calE			INTRA	CRANIAL	. HEM	ORRH.	AGE				
9	ifficate g phys as the	edic		- u									
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 💆 No 9 ☐ Unknown		e of pregnancy 2 Fetal death at time of death	3 □Ectopic pr 5 □ Other (sp					2	3d. Date of o	delivery Day Year
٥	res that t igned by be detad		Part II. Other significant condition	ns contributing to death I	but not resulting in	the underlying o	ause give	n in Part I	l.	23e. Did to	obacco us	se contribute	to the cause of death?
rds	quires n sign	d by								1 🗆 Y	es 20)	(No 3□	Probably 4 Unknown
Records,	s been s shoul	Completed								24a. Was	an	24b. Were	autopsy findings available
Re	The lav	E O				~					rmed?	prior t death	o completion of cause of ?
Vital	len: Th rtificate tor. pag	0	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes (Check only o	2 💢 No ne)	1 🗆 Y	es 2 No
of V	Physiclen: this certificaral director.	To B	examiner? 1 □ Yes 2 🌠 No	Hospital: 1 Inpati	ent 2 ER/Out	patient 3 DC	Othe	r: 4 💢 Ni	ursing Hor	ne 5 Resid	lence 6	□Other (S)	oecify)
	ding Ph h. After thi funeral	ü	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. T	ime of 2 njury	8c. Injury Work	at ?	2	28d. Describe h	ow injury	occurred	
Sio	en eat ber: he	catl	2 Accident investig 3 Suicide 6 Could n	ation		М	1 🗆 Y	'es 2 □	No				
Division		Certification:	4 Homicide determi	ned 286. Place of in building, e	ijury - At home, far tc. (Specify)					City or Tow	m, State)		Rural Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	ledical	one)	Physician: To the best exeminer: On the basis of and manner s	of examination and	Vor investigation	in my op	inion, dea	nd place, a ath occurre	and due to the ded at the time, d	ause(s) a date and	and manner place, and d	as stated. ue to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	M. 3			License				29d. Dat	20	nth, Day, Year)
٠,		2	that	- M.D			230	132	-		2/1	6/02	
1	1			vho completed cause of			MD	2005	0		1	6	
V	Sta	to	14804 PHYSIC		ZZI KUI rar's Signature	CKVILLE.	, טויו	2000	U				
	Registr				and the second	10 A	. M						
DHI	MH 17 Rev 1/2	001	901	1 - 4000	Meser.	AT ASSE							

ORIGINAL

			State of Maryland / Department of Health and Mental Hygiene	
			1- State State Certificate of Death Reg. No. 005	3328
	Physic		1. Decedent's Name (First, Middle, Last) RAMUNAS J NOREIKA 2. Date of Death Month Day Year MAY 30, 2005	Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	10377
		ш	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (5	
E	Funeral Director		T∰ M 2□ F Yrs Months Days Hours Min. (Month, Day, Year) Country	State or Foreign
	and		Usual Residence of Decedent	side City Limits
	Maryls -f sho	to		Tes 21 No
	ith the	Olrec	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
	eath w	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	l'an
9	after d or Itam calcul	Fun	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No	nan,
21215-0036	permit. Pages 1 and 2 should be lifed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show ship injury or other traumatic avant, the Medical Examinan must be notified at 2006.	d by	3 Wildowed 4 Divorced Year or Dates:	Σ.
215-	nin 72 un "nat	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry	
	filed with Hygiene. thar than	Com	12785 F. S.F. V.S. A.F.	
Maryland	ould be fil Mental H arked ott	o Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 18. Mother's Name (First, Middle, Maiden Sumame) 18. Mother's Name (First, Middle, Maiden Sumame)	-E
ary	2 should be and Mental is marked c sumatic ave	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	31234
	1 and 2 Health a am 27 is		DIANA NORZIKA STIALIZADAL ROPO PARKVILLE MARNIAN	0
Baltimore,	Pages 1 nent of H int: If ita		20a. Method of Disposition 1 Burial 2 Scremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Localion - City or Town, St. Community of Community Comm	tate
altin	permit. Pages Department of Important: If it any injury or c	1	21 Sports of Figure Sports icenses	2024
ä	Depa Impo any ii		MAR IT MY SERONARED PARKY, WILL PROLAD	D
			shock, or heart failure. List only one cause on each line.	oximate val Between it and Death
	Prrysician /Medical		Immediate Cause (Final disease or condition resulting in death) a. ASPHYXIA BY HANGING Due to (or as a consequence of):	inutes
	Examiner		Sequentially list conditions b.	
7	red sit	Examiner	Cause, Enter Underlying Cause (Disease or injury	
ď	be executed sician and burial-transit		that initiated events c. resulting in death) Last Due to (or as a consequence of):	
8760,	9 × 9	dical	d	
Box 6	leath certifica attending ph I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery	
	ed for	sicia	in the past 12 months? 1	Year
P.0	that the de ad by the detached		9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause	se of death?
rds,	w requires tha been signed I should be det	ed by		4 Unknown
Vital Records,	ne law rev has bee ge 2 sho	Completed	24a. Was an 24b. Were autopsy find autopsy prior to completion	dings available
al R	ate pag		performed? death? 1 Yes 2 No 1 Yes 2 No	r ^a
		o Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Presidence 6 Other (Specify)	
n of	iding Phys th. After this funeral di	T :uc	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	2 /
Division	Attanding ir death. actor: After by the funer	ertification;	2 Accident investigation MA 38 20 0 5 GH3 A M 1 Yes 2 No ASPHYXIA BY ALL	
Div	al or Attand s after death Il Diractor; , id in by the f	Certif	28e. Pace of Injury - At home, farm, street, factory, office building, etc. (Specify City or Town, State)	ALC Rd.
7	To the Hospital or within 24 hours after To the Funeral Director Completely filled in b	edical (29a. Certifier (Check only (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	uuse(s)
	o the lithin 2 o tha complet	Med	and manner stated. 29b. Signature and title of-certifier 29c. License number 29d. Date signed (Month, Day, Ye	
	r > F 0	1		•
1	'atl		30. Name and address of person who completed cause of death (term 25a) (type, Print)	>
	Sta		31. Date filed (Month, Day, Year) 32_Registrar's Signature	J
J.	Registr	ar	JUN 0 1 2005 Per 12 Accept	

DHMH 17 Rev 1/2001

ORIGINAL

	1	For State Registrar	Otate of	Maryland	•		of Dea			giene Reg. No	41111	1832
ysician	_	Decedent's Name (First, Middle, L	(6.)	-1					2. Date of De	ath Day	Yea	3. Time of Dear
Medical		Maria E		sls					May	27	200	
caminer	4	a. Facility Name (If not institution, g		ber)		,		tion of Death		4c.	County of D	
	5	5412 White Mar Social Security Number 6.		. Age (In yrs. la	st hirthday)	If Under 1	olumb:	La nder 24 Hrs.	8 Date of Bir	th	Howar	
neral ector		042-28-3037	1□M 2⊠F	94	Yrs.		Days Ho		8. Date of Bir (Month, Da April	20,1	911 L	Birthplace (State or For Country) atvia
=	-	Usual Residence of Decedent Oa. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Lir
tor to	N	Maryland Howard	1		Co1um	hia						1 ☐ Yes 2 %
any Injury or other treumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1	0e. Street and Number			Jordin	10f. Zip C	ode			10g. Citi	zen of What	Country?
al D		5412 White Mane	<u> </u>				21045	5			Latvi	а
t, the Medical Examinat must Completed by Funeral	1	1. Marital Status	12. Was Deced	dent Ever in U.S	. 13.	Vas Decede	nt of Hispani y Cuban, Me	c Origin? (Spe xican, Puerto	ecify Yes or No Rican, etc.))-	14. Race - A Black, W	merican Indian,
y Ft		1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give			Yes 2		ecify:			Specify:	
ed be	-	15. Decedent's I	Year or Dat		16a Decer	fent's Henal	Occupation			16b K	nd of Busine	White
plet	_	(Specify only highest g	rade completed)	45	(Give	kind of work DO NOT use	done during retired)	most of worki	ng	I OD. IX	na or basine	samoustry
E E		Elementary/Secondary (0-12)	College (1-	40r 5+)		Homen	aker				Own H	ome
event, Be C		7. Father's Name (First, Middle, Las	st)				18. N	lother's Name	(First, Middle	, Maiden	Sumame)	
10 L	;	Unknown						Unkno	wn Bru	zins	ki	
me l	1	19a. Informant's Name/Relationship							I Route Numb	-		
hert	_		Daughter			White	v. de la companyation		ıbia, M			
0 10	12	0a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3		tato		sition (Name natory or oth		I		20c. Lc	cation - City	or Town, State
dury	-	' 4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Fundal Service Lice		Ches				6-1-			sville	e, Maryland
once.	1	11. Signature of Fundral Service Lice	eosee	///	พื่	tzke	Funera	1 Home	s, Inc			
	+	23a. Part1. Enter the disease, or	molications that ca	used the death.							a, Mar	yland 2104. Approximate
		23a. Part1. Enter the disease, or shock, or heart failure. List only immediate Cause (Final		1	U	.+	- 1					Interval Between Onset and Death
ian ical		disease or condition resulting in death)	a	or s a conseque	once of:	24Y1	1 = 1 / v	re				Jereve 1 110
ner			11.1	rtn	inh							20 /ters
ne 💻	i i	Sequentially list conditions, frank, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to to	ras a conseque	ence of:							1
Examiner	t	Cause (Disease or injury hat initiated events resulting in death) Last	c									
	i i		Due to (o	r as a conseque	ence of):							
												335000 SOUR TOPS
icai			d									
icai		F FEMALE:	d	ome of pregnant	cy						23d Date of	delivery
cal		F FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live bir	ome of pregnand th 2 Fetal o	death 3	Ectopic pred					23d. Date of Month	delivery Day Year
cai		F FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live bir	th 2□Fetalo .nt at time of dea	death 3					:		,
Physiclan/Medical		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠No	23c. If yes, outc 1□Live bir 4□Pregna 9□Unknov	th 2 □ Fetal o .nt at time of dea wn	death 3 (Other (spec	cify)	Part I.	23e. Did 1		Month	,
by Physician/Medical	- I 2	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outc 1□Live bir 4□Pregna 9□Unknov	th 2 □ Fetal o .nt at time of dea wn	death 3 ath 5 ath 5 ath 5 ath 5 ath 5 ath	Other (spec	cify)	'art I.			Month se contribute	Day Year
pleted by Physician/Medical	- I 2	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome to the second of the se	th 2 Fetal on the attime of deal with but not result	death 3 ath 5 ath 5 ath 5 ath 5 ath 5 ath	Other (spec	use given in F	'art I.	1 🗆 24a. Was	obacco u Yes 2	Month se contribute No 3	Day Year to the cause of death' Probably 4 Unknown autopsy findings availa
by Physician/Medical	- I 2	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outc 1 Live bir 4 Pregna 9 Unknow	th 2 Fetal on the attime of deal with but not result	death 3 ath 5 ath 5 ath 5 ath 5 ath 5 ath	Other (spec	use given in F	art I.	24a. Was	obacco u Yes 2	Month se contribute No 3 24b. Were prior death	Day Year to the cause of death' Probably 4 Minknot autopsy findings availate to completion of cause
pleted by Physician/Medical	P 2	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome to the contribution of the contribution to dear the contribution the contribution the contribution to dear the contribution th	th 2 Fetal on the attime of deal with but not result	death 3 ath 5 ath	Other (spec	ise given in F		24a. Was	obacco u Yes 2 an osy ormed? 2 No	Month se contribute No 3 24b. Were prior death	Day Year to the cause of death' Probably 4 Winknot autopsy findings availate to completion of cause
pleted by Physician/Medical	P 2	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 28 No 9 Unknown Part II. Other significant conditions Chyshiz Obs Mitral Resure 25. Was case referred to medical examiner? 1 Yes 25 No	23c. If yes, outc	th 2 Fetal contact time of dealers with the second at the but not result Fetal contact F	death 3 □ ath 5 □ ting in the ur	Other (special dentying caused by 15 and 15	ise given in F	Place of Death	24a. Was auto perfu 1 Yes auto perfu 1 Y	obacco u Yes 2 (an oby ormed? 2 No	Month se contribute No 3 24b. Were prior death 1 Y	Day Year to the cause of death' Probably 4 Onknot autopsy findings availate to completion of cause es 2 \sum No
pleted by Physician/Medical	P 2	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions Chyplic Obs 75. Was case referred to medical examiner? 1 Yes 2 No 76. Manner of Death 1 Natural 5 Pending	23c. If yes, outcome to the second of the se	th 2 Fetal contact time of dealers with the second at the but not result Fetal contact F	death 3 □	Other (special orderlying cau by 15 c	26. I Other: 4 { Co. Injury at Work?	Place of Death	24a. Was auto perfit 1 Yes	obacco u Yes 2 (an oby ormed? 2 No	Month se contribute No 3 24b. Were prior death 1 Y	Day Year to the cause of death' Probably 4 Onknot autopsy findings availate to completion of cause es 2 \sum No
pleted by Physiclan/Medical	P 2	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outc	th 2 Fetal ont at time of dealers ath but not result patient 2 E	death 3 □ ath 5 □ ting in the un ti	Other (special orderlying cau) / 5 2	26. I Other: 4 (Work? 1 Yes	Place of Death Nursing Hoi	24a. Was auto perfet 1 Yes 1 (Check only was 5 Resident) Resident Describe	obacco u Yes 2 { an osy ormed? 2 no one) dence (how injur	Month se contribute No 3 24b. Were prior death 1 Y	Day Year to the cause of death' Probably 4 Unknot autopsy findings availate o completion of cause es 2 \sum No
z snould be detached for use as the but pleted by Physician/Medical	P 2	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions Chysin I Cobs Mittal Cobs 25. Was case referred to medical examiner? 1 Yes 2 No 17. Manner of Death 1 Natural 5 Pending investigating	23c. If yes, outcome the contributing to death of the contributing to death of the contributing to death of the contributing to death of the contributing to death of the contributing to death of the contributing to death of the contribution on the contribution of the contribution on the contribution of the contribution on the contribution of th	th 2 Fetal ont at time of dealers ath but not result Pulm patient 2 E E Injury 2	Algorithm 1 Section 1 Sect	Other (special orderlying cau) / 5 2	26. I Other: 4 (Work? 1 Yes	Place of Death Nursing Hoi	24a. Was auto perfet 1 Yes 1 (Check only was 5 Resident) Resident Describe	obacco u Yes 2 { an osy ormed? 2 P No one) dence { how injur	Month se contribute No 3 24b. Were prior death 1 Y Compared A Number or	Day Year to the cause of death' Probably 4 Onknot autopsy findings availate to completion of cause es 2 \sum No
pleted by Physician/Medical	P 2	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions Chyshic Obs Mitral Cesure 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigate 3 Suicide 6 Could not determine 29a. Certifier 1 Certifying F	23c. If yes, outcome the contributing to deal the contributing to deal the contributing to deal the contributing to deal the contributing to deal the contribution on the contribution to deal the contribution on the contribution on the contribution on the contribution on the contribution on the contribution on the contribution on the contribution on the contribution on the contribution on the contribution on the contribution on the contribution on the contribution on the contribution on the contribution of the contribution on the contribution of the contribution on the contribution of the contribution on the contribution on the contribution on the contribution of the contribution on the contribution of the contribution on the contribution of the contribution of the contribution of the contribution of the contribution of the contributio	patient 2 Einjury, Day Year)	EVOutpatien 28b. Time of Injury	t 3 DOA Meet, factory,	26. I Other: 4[c. Injury at Work? 1 Yes office	Place of Death Nursing Hoi 2 \[\text{No} \]	24a. Was auto perful yes of (Check only was 28d. Describe 28f. Location (City or To	obacco u Yes 2 (an Dosy Drimed? 2 No Done) dence (how injur Street an wn, State cause(s)	Month se contribute No 3 24b. Were prior death 1 5 6 Other (S y occurred of Number or)	Day Year The to the cause of death' Probably 4 Unknot autopsy findings availate to completion of cause? The second of the sec
pleted by Physician/Medical	P 2	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions Chyshic Obs Mitral Cesure 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigate 3 Suicide 6 Could not determine 29a. Certifier 1 Certifying F	23c. If yes, outcome the contributing to dear the contributing to dear the contributing to dear the contributing to dear the contributing to dear the contributing to dear the contribution the contribution to dear the contribution to dear the contribution to dear the contribution to dear the contribution to dear the contribution to dear the contribution to dear the contribution the contribution to dear the contribution to dear the contribution to dear the contribution to dear the contribution to dear the contribution to dear the contribution to dear the contribution the con	patient 2 E [Injury, At homg, etc. (Specify)]	EVOutpatien 28b. Time of Injury	t 3 DOA Meet, factory,	26. I Other: 4[c. Injury at Work? 1 Yes office	Place of Death Nursing Hoi 2 \[\text{No} \]	24a. Was auto perful yes of (Check only was 28d. Describe 28f. Location (City or To	obacco u Yes 2 (an Dosy Drimed? 2 No Done) dence (how injur Street an wn, State cause(s)	Month se contribute No 3 24b. Were prior death 1 5 6 Other (S y occurred of Number or)	Day Year The to the cause of death' Probably 4 Unknot autopsy findings availate to completion of cause? The second of the sec
pleted by Physician/Medical	P 2	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions Chyshic Description 25. Was case referred to medical examiner? 1 Yes No 26. Wanner of Death 1 Natural 5 Pending investigate 27. Manner of Death 1 Natural 1 Natural 28. Suicide 1 Could not determine 29a. Certifier 1 Certifying Factors 29a. Certifier 1 Certifying Factors 29b. Medical Example 21 Medical Example 21 Medical Example 21 Medical Example 22 Medical Example 23 Medical Example 24 Medical Example 25 Medical Example 26 Medical Example 27 Medical Example 28 Medical Example 29 Medical Example 20 Medical Example 21 Medical Example 22 Medical Example 23 Medical Example 24 Medical Example 25 Medical Example 26 Medical Example 27 Medical Example 28 Medical Example 28 Medical Example 29 Medical Example 20 Medical Example 25 Medical Example 26 Medical Example 27 Medical Example 28 Medical Example 28 Medical Example 28 Medical Example 28 Medical Example 29 Medical Example 20 Medical Example 28 Medical Example 29 Medical Example 20 Medical Exam	23c. If yes, outcome to the contributing to dear the contributing to dear the contributing to dear the contributing to dear the contributing to dear the contributing to dear the contribution to the contribu	patient 2 E [Injury, At homg, etc. (Specify)]	EVOutpatien 28b. Time of Injury	t 3 DOA 28 M occurred at vestigation, i	26. I Other: 4[c. Injury at Work? 1 Yes office	Place of Death Nursing Holi 2 No te and place, death occurriber	24a. Was auto perful yes of (Check only was 28d. Describe 28f. Location (City or To	obacco u Yes 2 { an DSY DTMed? 2 P No Dne) dence (how injur Street and wn, State cause(s) date and	Month se contribute No 3 24b. Were prior in death in yearth in	Day Year To to the cause of death' Probably 4 Onknot autopsy findings availate to completion of cause? Yes 2 No Procify) Rural Route Number, as stated. Autopsy findings availated to completion of cause of the cause of
pleted by Physician/Medical	P 2	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions Chyshic Description 25. Was case referred to medical examiner? 1 Yes 2 No 26. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide Gould not determine 29a. Certifier (Check only one)	23c. If yes, outcome to the contributing to dear the contributing to dear the contributing to dear the contributing to dear the contributing to dear the contributing to dear the contribution to the contribu	patient 2 E [Injury, At homg, etc. (Specify)]	Elodge, death on and/or inv	t 3 DOA 28 Moeet, factory, occurred at vestigation, i	26. I Other: 4[D. Injury at Work? 1 Yes office	Place of Death Nursing Ho: 2 No te and place, death occurr	24a. Was auto perfu perf	obacco u Yes 2 { an Dosy Drmed? 2 No Done) dence thow injur Street and wm. State cause(s) date and	Month se contribute No 3 24b. Were prior in death in yearth in	Day Year To to the cause of death' Probably 4 Onknot autopsy findings availate to completion of cause? Yes 2 No Procify) Rural Route Number, as stated. Autopsy findings availated to completion of cause of the cause of
led in by the funeral director, page 2 should be detached for use as the but Certification; To Be Completed by Physician/Medical	P 2 2 3	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions Chyshic Description 25. Was case referred to medical examiner? 1 Yes 2 No 26. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide Gould not determine 29a. Certifier (Check only one)	23c. If yes, outcome the pregnance of th	patient 2 E Injury Dest of my knows sis of examination of death (Item 2)	Elodge, death on and/or inv	t 3 DOA 28 Moeet, factory, occurred at vestigation, i	26. I Other: 4[D. Injury at Work? 1 Yes office	Place of Death Nursing Ho: 2 No te and place, death occurr	24a. Was auto perful yes of (Check only was 28d. Describe 28f. Location (City or To	obacco u Yes 2 { an Dosy Drmed? 2 No Done) dence thow injur Street and wm. State cause(s) date and	Month se contribute No 3 24b. Were prior in death in yearth in	Day Year to the cause of death' Probably 4 Unknot autopsy findings availate to completion of cause? es 2 No Pecify) Rural Route Number, as stated, fue to the cause(s)

		1	For State Registrar	State of Marylan		artment of I			Reg	ene 0	05	18330
	Physicia		1. Decedent's Name (First, Middle, Last)		0.0	TOOFF		N	ate of Death Month	Day	Year	3. Time of Death 9:50pm M
	/Medic	al .	JACOB ta. Facility Name (If not institution, give :	street and aumhor)	05	TROFF 4b. City, Town, 6	or Location of		May 27	, 2005 4c. Count		
	Examin	er '	Greater Baltimore		er	Towson				Balt:	imore	
	Funeral Director		5. Social Security Number 6. Sex			If Under 1 Year Months Days	If Under 2 Hours	Min. 8. D	Vate of Birth Worth Day, 1	913	9. Birth Cou	place (State or Foreign intry) PA
	and w	- H	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ocation			,			10d. Inside City Limits
	Maryi f sho	tor	MD BALTI	MORE	PIKE	SVILLE						1 ☐ Yes 2 No
	th the	Director	10e. Street and Number			10f. Zip Code	0100	0	100	g. Citizen of	What Cou	intry? USA
	s 23a	ral	725 MT. WILSON L	ANE #203 12. Was Decedent Ever in U.	S 13	Was Decedent of	2120		Yes or No-	14. Ra	ce - Amer	ican Indian,
39	urs after de al', or ttams xantinal n	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 N No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 🛱 No		, Puerto Rica	n, etc.)		ack, White	
215-0(be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or itams 23a or 28a-f show avent. The Medical Exert for must be notified at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give	dent's Usual Occu e kind of work done DO NOT use retin	during most	of working		MEDIC		ndustry
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or thams 23a or 28a-f show important: If itam 27 is marked other than "natural", or thams 23a or 28a-f show important it itam 27 is marked other than a state of the profiled at any injury or other traumatic avant. The Marked Examiner must be notified at ance.	To Be Cor	17. Father's Name (First, Middle, Last) SAMUEL	T	OSTR			r's Name (Fir	rst, Middle, Ma			BLANK
lary	2 should and Men is marka raumatic		19a. Informant's Name/Relationship (7)	_		MT. WILS						
	1 and Health am 27 thar to		MARY OSTROFF / W 20a, Method of Disposition	1 F E 20b. F	Place of Disp	osition (Name of		Date	-	Oc. Location		
TOL	Pages nent of int: If it		1 X Burial 2 □ Cremation 3 □ F 4 □ Doration 5 □ Other (Specify)	removal from state		matory or other pl		5/30/2	2005	REIST	ERST(OWN, MD
Baltimore,	permit. Pages Department of H Important: If its any injury or of		21. Signature of Funeral Service Licens	1-4	2	2. Name and Add	ess of Facilit	y SOL L	EVINSO			
0	20 E 29		23a. Phrt1. Enter the disease, or comp shock, or heart failure. List only of	lications hat caused the deat	h. Do not er	3900 REIS	TERSTO	JWN_KOP cardiac or res	AD - PI spiratory arres	KESVI	LLE,	MD 21208 Approximate
	Physician		Immediate Cause (Final	DECDIR	47 () K	Y + M	ILUR	E				Interval Between Onset and Death
ı	/Medical		disease or condition resulting in death)	Due to (or as a consect	uence of):	NICTO						YEARS
	Examiner	<u></u>	Sequentially list conditions,	b. Due to (or as a consec	uence of):	IVCER						1011-7
,	s be executed sician and burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consec	quence of):							
8760,	± × €	dicai	(d								
.O. Box 68	at the death certificat by the attending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of α 9 □ Unknown	al death 3	□Ectopic pregnan	cy				Date of deli	very Day Year
<u>α</u>	uires that t signed by Id be deta	by	Part II. Other significent conditions co	ontributing to death but not res	sulting in the	underlying cause (given in Part I			acco use co s 2 □ No	ntribute to	the cause of death?
Records,	The law requires that the rate has been signed by the page 2 should be detached.	Completed							24a. Was an autopsy perform	/	prior to death?	topsy findings available completion of cause of
Vital		BeC	25. Was case referred to medical examiner?					of Death (C	heck only one			
of V	di S	To	1 ☐ Yes 2 ☑ No		ER/Outpati	ent 3 DOA			5 Reside			cify)
	Jing After fune	tion:	27. Manner of Death 1 ∑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	W	ork? □Yes 2□		. 26301100 110	ii iigary ooo	41100	
Division	or Attanding after death. Diractor: After din by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		nome, farm, s ify)	street, factory, office	8	28f.	Location (Str City or Town	eet and Nur , State)	mber or Ru	ıral Route Number,
	Hospita 24 hours Funeral	edical C	29a. Certifier (Check only one) Check only one)	ysician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, de ation and/or	investigation, in m	y opinion, dea	ath occurred a	at the time, da	ite and place	e, and due	to the cause(s)
	To the Within To the comple	Me	29b. Signature and title of certifier	L MO		29c. Lice	nse number	2	29	Od. Date sign	ned (Mpnt)	h, Day, Year) 1 5
,		*	Tomace Page			D (21 11	2		0) 0	2010	4.1/
(00		30. Name and address of person 670/ NORTH CH/	IPLESST, 10)WSO	M MO	2120)4 T	O MA	sz f	AJ	AK
	e ∫St	ate	31. Date filed (Month, Day, Year)	32. Registra Sign	nature	1 Apane						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 8:05 AM Mary Catherine O'Donnell 2005 MAY 27 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST. MGNES HEALTHCARE BALTIMORE If Under 1 Year | ff Under 24 Hrs. Months Days Hours | Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) Birthpface (State or Foreign Country) 1 ☐ M 2 🖾 F Yrs. 219-01-9603 95 Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Fairfield Drive 21228 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 XX Married 1 ☐ Yes 2 X No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Complet Elementary/Secondary (0-12) College (1-4or 5+) 4 Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Joseph Nolan Mary Peddicord 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Fairfield Prive; Catonsville, MD 21228 ce of Disposition (Name of Date 20c. Location - City or Town, State John O'Donnell, Sr. Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State New Cathedral Cemeteny 6/1/2005 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Avenue; Catonsville, MD 21228 ADDROXIMATE 21. Signature of Funeral Service License Approximate Interval Between Onset and Death S 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. fmmediate Cause (Final disease or condition resulting in death) BOWEL ISCHEMIA Due to (or as a consequence of) ATHEROSCIERCESIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Year 4□Pregnant at time of death 5 Other (specify) Part IL Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? VASCULAR 2 No 3 Probably 4 Unknown 1 ☐ Yes 1 DRATION 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No DYSPHAGIA 1 Yes 2000 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: spital: 1 Impatient 2 28a. Date of Injury (Month, Day Year) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident

/Medical Examiner physician and s the burial-transit ō of Vital To the Hospitel or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Examiner Completed by Physician/Medical Be Medical Certification: To 3 🗌 Suicide 4 Momicide 29a. Certifier

Physician

Funeral

Director

or 28e-f show

or items 23e

"natural",

d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other then "r

if item 27

permit. Page Department of Importent: If any injury or once.

Physician

Baltimore, Maryland 21215-0036

Directo

froumatic event, the Medical Examinations by notified at

29b. Signature and title of pertitier

6 Could not be

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) MAY 27, 2005

040012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) O, SUITE DOY, CATONS WILLE, MD 21228

28f. Location (Street and Number or Rural Route Number, City or Town, State)

31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature

Steen & Sparte

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death I. Decedent's Name (First, Middle, Last) May 27, Year **Physician** 2005 4:30AM M Mildred M. Odrowas /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Golden Crest Assisted Living Hampstead If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth Month, Pay, Year) Sept. 16, 1914 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2 ☑ F Pennsylvania Yrs. 209-07-4041 90 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examinar coust be notified at 1 Yes 2 No Director MD N/A Baltimore 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number ŏ 2810 Rueckert Avenue 21214 U.S.A. or Items 23a Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Care Giver Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Kandra Helen unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joanne M. Prell- Daughter 3829 Devonshire Road Hampstead, Maryland 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 5/31/05 Baltimore, Maryland 21. Signature of Funeral Service Licensee Heather Cain 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician LIWK /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner vascular disaxo that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physiclan/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 wonths?

1 Yes 2 DNo 23d. Date of delivery 3 Ectopic pregnancy Month Day detached for 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 X No 1 ☐ Yes I or Attanding Physician: after death. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 6 Other (Speci 2 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence tilled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide within 24 hours a To the Funeral (1 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only Signa ompleted cause of death (Item 23a) (Type, Print

DHMH 17 Rev 1/2001

State Registrar

			1 - For State Registrar	State of N	laryland / D	•	rtment c			ınd M	ental Hy	giene Reg. No	711115	Property Aud	8333
	Physici		1. Decedent's Name (First, Middle Walter Edward	•							2. Date of De Month	aath Da		3. Ti	ime of Death
	/Medic Examir		4a. Facility Name (If not institution	o, give street and number	RE		4b. City, Tov	TI	moi	RE		40	County of Dea		
	Funeral Director		5. Social Security Number 215-07-4221	6. Sex 7. A	nge (In yrs. last birth 91 Y	rs.	If Under 1 Y Months D	ays	Hours	Min.	8. Date of Bir (Month, Da 05-28-	th ay, Year) I913	9. Bir Co Mar	thplace (Sountry) ylanc	State or Foreign
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County MD Balti	more	10c. City, Town				<u> </u>						ide City Limits
	and the	I Direc	10e. Street and Number 8220 Arbour Si	de			10f. Zip Co 2122					10g. Ci	tizen of What Co	ountry?	
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than *natural', or items 23a or 28a-f ahow important: If item 27 is marked other than *natural', or items 23a or 28a-f ahow important in the modified at the property of the profiled at an once.	by Funeral Director	11. Marital Status 1 Never Married 2 Marria 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 Tyes 2 If Yes, Give Year or Dates	s? X No		Vas Decedent Yes, specify ☐ Yes 2 ☑		panic Orig , Mexican, Specify:	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)		14. Race - Ame Black, Whit Specify: W	e, etc.	an,
21215-0	filed within 72 ho Hyglene. Nher than "natur ant, I'v. Medical	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12) 1.2		r 5+)	(Give I life. D	ent's Usual O kind of work d OO NOT use ro	lone du etired)	ring most		ıg		and of Business	/Industry	
	t be filed ntal Hyg ad other evant,	Be	17. Father's Name (First, Middle, Walter Price,		1 ====			1		r's Name	(First, Middle				_
Maryland	12 should be n and Mental sis markad or raumatic eve	To	19a. Informant's Name/Relations Walter E. Pric	hip (Type, Print)				reet an	d Numbe	r or Rura	Route Numb	_	or Town, State, 2		
	jes 1 and of Health of Health If itam 27 or other tr		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		20b. Place of l	Dispos		of	1		ate		ocation - City or		ate
Baltimore,	permit. Pages Department of I Important: If its any injury or o		4 Donation 5 Other (S 21. Signature of Funeral Service	pecify)	Lorrai								ltimore tus MD 2		
8760, 冬	Priysician Medical Examiner with price pri	dical Examiner	23a. Part. Enter the disease, of shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	of the death. Do not line. BROVAS. s a consequence of the consequence	1): 10A	JAR	ACUD	C	ex T	-Lef-T	He	mispha antail Ceness	Interva Onset	al Between and Drath 24 Marie 2 days
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 ☐ Fetal death at time of death		Ectopic pregn Other (specif						23d. Date of del Month	livery Day	Year
ds, P	uires that n signed b lld be deta	by	Part II. Other significant condition BACTERIA	ENCOCAR	but not resulting in	the un	derlying caus	ζ_	in Part I.			obacco Yes 2	use contribute to		e of death?
al Records,		e Completed	Pseudomem HEART dis 25. Was case referred to medica	branou. ease	s Coli	TIS	, Ce	DRO	NAR	4	1 ☐ Yes	psy ormed? 2 No	prior to death?	completion	dings available n of cause of
on of Vital	ding Ph h. After th funeral	To B	examiner? 1 Yes 2 No 27. Mann f Death 1 atural 5 Pendir	Hospital: 1 Impa 28a. Date of In (Month, D			28c.	Other Injury a Work?	4 □ Nur	rsing Hon 2	(Check only one 5 ☐ Resi	dence	6 □Other (Spe ry occurred	cify)	
Division	I or Attending after death. Diractor: After I in by the fune	Certification;	2 Accident Investig	not be 28e. Place of I	njury - At home, fari etc. <i>(Specify)</i>	m, stre				_	8f. Location (City or To		nd Number or Ru a)	ural Route	Number,
	To tha Hospital or Attani within 24 hours after deat To tha Funaral Diractor: completely filled in by the	edical C	29a. Certifier 1 Certifyir (Check only one)	g Physician: To the bes Examiner: On the basis and manner:	of examination and	death /or inv	occurred at the estigation, in	ne time my opir	, date and nion, deat	d place, a	nd due to the	cause(s date and) and manner as d place, and due	stated.	use(s)
	To # within To # comp	Me	29b. Signature and title of certifie	ATTER	uding Pla	1.451	29c. Li	cense		200	>	29d. Da	te signed (Mont	LOC	ear)
			30. Name and address of person	who completed cause of	720 -C	ype, F	Print)	4 (401	ce	LA, CA	TOR	sville,	ME	21228
₩.	Sta Registi		31. Date filed (Month, Day, Year	JN 0 1 20059is	trar' Signature	J.	Apa	W							

			1 - For State Registrar	State of Maryland	Department of H Certificate of the			ene 0 0 5	18334
			1. Decedent's Name (First, Middle, Last)		0		2. Date of Death Month	Day Year	3. Time of Death
	Physici: /Medic		SEAN		PFEFF		MAY	29 2005	12:42 FM
	Examin	er	4a. Facility Name (If not institution, give si	1/		Location of Death	1	4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Birth Cop	plece (State or Foreign intry)
	a-f show	ctor	Usuel Residence of Decedent 10a. State 10b. County AD BALT V	UORE 10c. City, T	own or Location BALTIMO	CE			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	3a or 28 st be no	i Dire	10e. Street and Number	C+ Ap+ B	10f. Zip Code	234	100	g. Citizen of What Cou	intry?
99	s I and 2 should be lied within 72 hours also bean with the waryand Health and Mental Hygiene. I Health and Mental Hygiene. I Health and Mental Hygiene. I health and Mental Hygiene. Other traumatic event, the Medical Examinational be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 \(\text{Yes} \) 2 \(\text{No} \) No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
D-612	Min /z nou ne. nen "neture e Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation 1	6a. Decedent's Usual Occup (Give kind of work done) life. DO NOT use retired	during most of work	ing 16	Sb. Kind of Business/I	ndustry
	id be filed with ental Hygiene. ked other ther ic event, the N	To Be Col	17. Father's Name (First, Middle, Last)	Pfoffer	Pluncher	18. Mother's Nam	e (First, Middle, Ma	aiden Sumame)	ster
2	1 and 2 should by Health and Menta tem 27 Is marked ther traumatic ex		1111011011011011	amana-wife &	19b. Mailing Address (Street	row C	F. Apt. K	City or Town, State, Z	LORE, MD
HOLE	Pages 1 al nent of Hea int: If Item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ri 4 ☐ Donation 5 ☐ Other (Specify)	cem	e of Disposition (Name of etery, crematory or other play	PIL 10-1	-03	Forest H	// M/P
Dall	permit. Pages Department of Important: If It any injury or o		21. Signature of Funeral Service License	1. her bothers	22. Name and Addre	ss of Facility		MD 2123	
48			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	cations that caused the death.			or respiratory arres		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a consequen		CINO	MA		6 WEEKS
	be executed ician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer					
	6 × 6	lical	d	Due to (or as a consequer	ice or):				
ň	at the death certificate by the attending phys tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of pregnance 1 Live birth 2 Fetal de 4 Pregnant at time of deat 9 Unknown	ath 3 Ectopic pregnancy	1		23d. Date of deli Month	very Day Year
ecords, P.	The law requires that the tee has been signed by thoage 2 should be detached.	þ	Part II. Other significant conditions con	tributing to death but not resulti	ng in the underlying cause giv	en in Part I.		acco use contribute to	4. 1
		Completed					24a. Was an autopsy perform 1 Yes 2	prior to d	topsy findings available ompletion of cause of
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital: 64.	Ott		th (Check only one		
Ö	Phys	To	1 ☐ Yes 2 No	28a. Date of Injury 2	Bb. Time of 28c. Injur	y at	ome 5 Resident 28d. Describe hov	nce 6 Other (Spec	ary)
Division	tending Path. tor: After the funera	Certification;	1/25/Jatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year) 28e. Place of Injury - At hom	Injury Wo	rk? Yes 2 □No	28f Location (Stre	eet and Number or Ru	ral Route Number
∑ O	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.		4 Homicide determined	building, etc. (Specify)			City or Town,	State)	
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical		sician: To the best of my knowle ner: On the basis of examination and manner stated.					
	Totl withi Totl comp	Ž	29b. Signature and title of certifier		29c. Licens			d. Date signed (Monti	
	D		AAICC	-MD	KE	5-00	U M	1AY 29	2005
	10		30. Name and address of person who co	mpleted cause of death (Item 2	3a) (Type, Print)	4000	(rant	~	BALTIMURE
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	3a) (Type, Print) 3 HOPKINS)	L OUT NO	unwert r	18 JUNIV 10 212

amend item#1, perMD, G846,8/4/05 TT State of Maryland / Department of Health and Mental Hygiene | | | | | 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle Last)

Bonnie Prechtel 3. Time of Death Month Year **Physician** MACO /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Hospital Center ALLON Co If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 12, 1949 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 213-72-3630 1 ☐ M 2 🂢 F 55 Yrs. MĎ. Director Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10b. County Baltimore 10c. City, Town or Location
Dundalk 10a. State 10d. Inside City Limits if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Examinar must be notified at Md. 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7832 St. Bridget Ln. 21222 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 6 yrs. and Mental Hygiene. College (1-4or 5+) Never Worked N/A yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Heelth and Mental William Green Zelda L. Moses 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 to Department of Heelth ar Importent: if item 27 is any injury or other trausnce. 7832 St. Bridget Ln. Dundalk Md. 21222 Mark L. Green brother 20b. Place of Disposition (Name of 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State Bayview Crematory or other place Baltimore 2005 * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Funeral Hous Of Dundalk lers Point Rd. 21222 23a. Part . Finter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** GIUNDO /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit UR B1 that initiated events resulting in death) Last physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical use as the attending I IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Day Year Month 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached f 1 ☐ Yes 2 ☐ No. 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown D & C 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an N autopsy performed page certificate R 140 1 Yes 2 No 1 Yes 2 🗓 N or Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No မှ 1 🗆 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 DER/Outpatient 3 DOA this within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral or 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Naturat 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Fo the Hospitel 1 Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ehM 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) د 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 0 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 11 15 18336 AMEND ITEM #19b&30 PER FH Gentificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MONTH **Physician** 26, 2005 PADOW SYLVIA 9:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10069 WINDSTREAM DRIVE COLUMBIA HOWARD If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 11/01/3/4/913 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 NV **Funeral** 1 M 2 F NY 89 068-05-3850 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 le marked other than "naturel", or Items 23a or 28a-f ehow traumatic event, Ita Medical Examinar must be notified at 1 ☐ Yes 2 1 No Director HOWARD COLUMBIA MD 10f. Zip Code 10g. Citizen of Whal Country? 10e Street and Number 21044 U.S.A. 10069 WINDSTREAM DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, While, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Marned WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: by 3 Nidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOUSEWIFE 18. Molher's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be **FOREMAN** MIRINGOFF ANNA BARNETT 2 19b. Majiro Adress (Steet and Number or Rural Route Number, City or Town, State, Zip Code)
12 MOGUETTE ROW - YONKERS, N.Y. 10703 19a. Informant's Name/Relationship (Type, Print) NORMA CASTLE / DAUGHTER Health Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from Slate HILLTOP SERVICE CORP. 05/28/2005 TOWSON, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part. Enter he disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List byfly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final to ke **Physician** 5 mmute disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 30415 ASCUD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulling in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav Pregnant at lime of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 1 Yes 2 1 No or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpalient Other: 4 Nursing Home 5 PResidence 6 Other (Specify) Medical Certification; To 1 Yes 2 JHO 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending within 24 hours after deam.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 26,2005 may -mo 217821 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WARREN M. ROSS ELLICOTT CITY, MD 31. Date filed (Month, JUN 0 1 2005 3. Registrar's Signature State Registrar

		-	For State Registrar		Sta	ate of I	Maryland		artment of Hetificate of L		nd Me		gieņe Reg. No.	005	18337
			1. Decedent's Nar								2	2. Date of Dea	ath Day	Year	3. Time of Death
	Physicia /Medic		GRISEL	DA BROM	WELL I	PIET					i		28,	2005	11:30 A.M
	Examin	_	4a. Facility Name	(If not institution,	give street	and numb	er)		4b. City, Town, or PARKVI		Death			County of Dea ALTIMOF	
				EN RIDG	E_ROAI 6. Sex		Age (In yrs. I	act histhday)	If Under 1 Year	If Under 24	4 Hrs. s	R Date of Bird			thplace (State or Foreign
	Funeral Director		5. Social Security 217-07-		1 M 2		86 Age (III yrs. 1	Yrs.	Months Days		Min.	B. Date of Birt (Month, Pa 5/30/1	9 18	C	RYLAND
			Usual Residence												
	how		10a. State	10b. County			10c. City	, Town or Lo	cation						10d. Inside City Limits
	e Ma	cto	MD	BALTI	MORE		P	ARKVIL							1 ☐ Yes 2 X No
	hours after death with the Maryland tural; or Items 23e or 28e-f show al Ezara act out the multified at	Funeral Director	10e. Street and N	umber					10f. Zip Code 21234				10g. Citi:	zen of What Co USA	ountry?
	s 23e	era		EN RIDG			ent Ever in U.	S 13 1	اری ایم Was Decedent of Hi		in? (Spec	ifv Yes or No		14. Race - Ami	erican Indian,
	ter de Item Ineri	-un	11. Marital Status 1 □ Never Ma	rried 2 Marri	A	med Force	∍s?		f Yes, specify Cuba	n, Mexican,	Puerto R	ican, etc.)		Black, Whi	te, etc.
936	urs af	by		4 Divorced	lf.	Yes, Give ear or Date			1 ☐ Yes 2Ã☐ No	Specify:				Specify: W	HITE
200	I within 72 hours after death with the Marylan liene. I then "natural", or Items 23e or 28e-f show The Medical Examinat must be mulified at	Completed	(Sp	15. Decedent	's Education	n npleted)		16a. Dece	dent's Usual Occupa	ation Juring most o	of working	g	16b. Kii	nd of Business	/Industry
21	within ene.	nple	Elementary/Sec	condary (0-12)	- -	oliege (1-4	or 5+)		kind of work done of DO NOT use retired)			OT.71	A LIOME	
12	filed within Hygiene. other thereaut, the Mant,	12TH G		asti			HOME	MAKER	18. Mother	's Name	(First, Middle,		N HOME Sumame)		
anc	nould be fi I Mental H narked ot natic avai	Be c		RNON BR								A SCHI		,	
Maryland 21215-0036	s 1 and 2 should be filed f Health and Mental Hyg itam 27 Is marked otha other traumatic avant,	4	19a. Informant's	Name/Relations	nip <i>(Type, P</i>	Print)		19b. Mailie	ng Address (Street a	and Number	or Rural	Route Numbe	er, City o	r Town, State,	Zip Code)
	and 2 sealth ar n 27 is		JUDITH	STAFFOR	D/DAU	HTER		200	HAMPTON R	OAD I	LINT	HICUM,	MD	21090	
re,	of Health itam 27 other tra		20a. Method of D		• CD	. 1	1 0	lace of Dispo	sition (Name of matory or other plac	θ)	Da	ite	20c. Lo	cation - City or	Town, State
E	Pages nent of ant: If it ary or o			2 □ Cremation 5 □ Other (S)		vai irom St		W CATH	EDRAL CEM		6/2/2	2005	BAI	LTIMORE	, MD
Baltimore,	permit. Pages 1 Department of H Importent: If ital any injury or ottl once.		21. Signature of	Funeral Service	Licensee	/									HOME, P.A.
ш	205 20		1780	Thu	0.	The f			521 LOCH er the mode of dyin				WSON	, MD	Approximate
			shock, or he Immediate Caus	eart failure. List	only one ca	use on' « ac	th line.					3	11631,		Interval Between Onset and Death
	Physician /Medical		disease or condi resulting in death	tion	a		as a conseq		AL IN	F196	/ (ch	,			SAME
	Examiner				1	Due to (0)	as a conseq	derice or).							
		ē	Sequentially list if any, leading to cause. Enter Un Cause (Disease	conditions, immediate	b. —	Due to (or	as a conseq	uence of):							
	cuted nd ransit	Examiner	that initiated ever	115	c.										
30,	be executed sician and burial-transit		resulting in death) tast		Due to (or	as a conseq	uence of):							
8760,	ete Se	dical			d										
Вох 6	leath certifica attending ph I for use as tl	Physician/Me	IF FEMALE: 23b. Was deced	ant pregnant	23c. II	yes, outco	me of pregna	ancy						23d. Date of de	livery
B	death e atter d for u	iciar	in the past	12 months?	4	Pregnar	h 2□Feta nt at time of d		⊒Ectopic pregnancy ⊒ Other (s <i>pecify)</i>					Month	Day Year
P.0	that the de led by the a detached f	hys	9 🗆 Unknov		9	Unknow	/n								
	es tha igned be de	by P	Part II. Other sig	nificant condition	ons contribu	iting to dea	th but not res	ulting in the u	inderlying cause give	en in Part I.			tobacco ι Yos 2		o the cause of death?
ord	w requir been si should											-			
Records,	has bu	Completed										24a. Was auto		24b. Were a prior to death?	utopsy findings available completion of cause of
a T	ate pa										15 11	1 ☐ Yes	2	1 ☐ Ye	s 2 No
Vital	Physician: Th this certificate ral director, pag) Be	25. Was case re examiner? 1 ☐ Yes 2		Hospi	ital: 1 🗆 In	patient 2	ER/Outpatie	nt 3 DOA Oth	or.		(Check only		6 □Other (Sp	acify)
of	Phys or this oral di	n: To	27. Manner of De	ath	21		Injury Day Year)	28b. Time o		y at		8d. Describe			
ion	Attending r death. ector: After by the fune	atloi	1 Natural 2 Acciden	5 Pendir investi	9	(NOTH)	Day rear)	Injury		Yes 2□N	No				
Division	r Atte er der recto by th	Certification;	3 🗍 Suicide 4 🗍 Homicid	6 ☐ Could determ		8e. Place o	f Injury - At h	ome, farm, st	reet, factory, office		2	8f. Location (City or To			Rural Route Number,
ā	itel or urs afte ral Dir				<u> </u>						1.1				
	To the Hospitel or Attending Phwithin 24 hours after death. To tha Funaral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one)	1 G-es rtifyir 2 Medical	Examiner:	n: To the bas On the bas and manage	is of examina	owledge, dea ation and/or i	th occurred at the tire evestigation, in my o	ne, date and pinion, deat	d place, a h occurre	and due to the and at the time,	date and	i and manner a I place, and du	is stated. le to the cause(s)
	o the ithin 2 o tha omple	Med	29b. Signature a	nd title of certifie			stated.	4	29c. Licens	e number			29d. Da	te signed (Mor	ith, Day, Year)
	⊢ s ⊢ ŏ		15	Trois	ry L	1	MIC	4	De	c 13	73		51	131/0	5
•	ίλ		30. Name and a	dress of person	who compl	eted cause	of death (Iter	m 23a) (Type				DILLE	-	cusan	und.
,			FRAL	ris x	CA	MCS	14 m	<u>D</u>	1200	CJLR		2,110		200-1	, 2ney
	St Regist	ate	31. Date filed (N	JUN 0 1	2005	32 Re	gistrar's Sign	arure	este 1						,
	ricgisi	TGI		-		FALL SE	appear in	3"							

		1 - For State of M		artment of Health and Martificate of Death	lental Hygiei	4000	18338
Physicia	an.	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
/Medic		Joseph D. Riley, Sr.			05-26-20		2:30 P. ^M
Examin	er	4a. Facility Name (If not institution, give street and number	r)	4b. City, Town, or Location of Death		4c. County of Death	
Funeral	-	6510 Ridenour Way 5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday)	Eldersburg If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Carrol1	ce (State or Foreign
Director		157M 2006	8 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Nov. 28, 1		y)
p ,		Usual Residence of Decedent			11011201		
aryla	5		10c. City, Town or Lo			104	d. Inside City Limits 1 ☐ Yes 2 ☑ No
the M	ect	Maryland Carroll 10e. Street and Number	Eldersh		100	China at Mina Cana	
Mith Ba or	Funeral Directo			10f. Zip Code		Citizen of What Countr	y r
death ms 23	era	11. Marital Status 12. Was Decede		21784 Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	S.A. 14. Race - America	n Indian,
or ite		1 Never Married 2 Married 1 Wes 2 If Yes, Give	∃No	f Yes, specify Cuban, Mexican, Puèrto	Rican, etc.)	Black, White, et	
5-0036 72 hours after death with the Maryland "neturel", or items 23a or 28e-f show occal Examiner must be natified at	d by	3 Widowed 4 Divorced Year or Date	WWII	1 ☐ Yes 2 🙀 No Specify:		Specify: White	e
- 9	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16b	. Kind of Business/Indu	istry
2121	dwo	Elementary/Secondary (0-12) College (1-4d	r 5+)	tant Engineer	To	lephone	
filed Hyg other	a	17. Father's Name (First, Middle, Last)	110010		e (First, Middle, Maid		
laryland 2121 2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than than the Mental	To B	Joseph Michael Riley		Joseph	ine Eff		
Maryland nd 2 should be file lith and Mental Hy 27 is marked oth treumatic event		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number or Run	al Route Number, Cit	ty or Town, State, Zip C	Pode)
		Mary Ellen C. Reese Day	ghter 10041	Whitworth Way, E.			
Baltimore, sernit. Pages 1 a Deportment of Hes mportent: If item nny injury or othe page.		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal from Sta	(B)	natory or other place) 5/31	Date 20c.	. Location - City or Tow	n, State
Baltimor permit. Pages Deportment of P Importent: If ite any injury or of ance.		' 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses		rk_Cemetery	Bal	Ltimore, Ma	ryland
Ba Perm Dep Imp any		De ment Co	more SI	erling Ashton Sch 6 Edmondson Avenu	wab Funera	1 Home, In	Ç
ENGLISH		23a. Part1. Enter the disease, or complications that cause	ed the death. Do not ent	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate
Physician		shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition		STITIAL LUDGE O	NC EALB.		nterval Between Onset and Death
/Medical		resulting in death)	as a consequence of):	SITTIFE	3 43.0		
Examiner		Sequentially list conditions.					
Sit 8d	line	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	as a consequence of):				
60, he executed be executed ician and burial-transit	Examiner	that initiated events c.	as a consequence of):				
66 be be	calE						
0 5 g	ed l	J					
Box 6	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcor 1 ☐ Live birth		Ectopic pregnancy		23d. Date of delivery	
. 5 . 5	Physician/M		at time of death 5	Other (specify)		Month D	ay Year
P.(Ph	Part II. Other significant conditions contributing to death	but not resulting in the u	nderlying cause given in Part I	23a Did tobaco	co use contribute to the	cause of death?
છ કુ છું કુ	d by			nadifying datase given in it acci.	1 ☐ Yes		oly 4 □Unknown
cord w requir	lete				24a. Was an	24h Wara autons	sy findings available
I Rec	Completed				autopsy performed	? prior to comp death?	oletion of cause of
Vital F sicien: Th certificate lirector, pag	Be C	25. Was case referred to medical		26. Place of Deat	1 ☐ Yes 202 h (Check only one)	No 1 Yes 2	□ No
	ToB	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpa	itient 2 ER/Outpatier	Cthon		6 ☐Other (Specify)	
on o ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month,	njury 28b. Time of Injury		28d. Describe how in		
Vision Attending r death. sctor: After	cati	2 Accident investigation		M 1 Yes 2 No			
Division of to Attending Physatter death. Director: After this lin by the funeral d	Certification:	determined 286, Place of	Injury - At home, farm, str etc. <i>(Specify)</i>	eet, factory, office	28f. Location (Street City or Town, St	and Number or Rural i ate)	Houte Number,
Divisio To the Hospitel or Attend within 24 hours after death To the Funerel Director; completely filled in by the fi		29a. Certifier 1 Certifying Physician: To the be	st of my knowledge, deatl	occurred at the time, date and place,	and due to the cause	e(s) and manner as stat	ed.
ths Ho nin 24 t the Fu	Medical	(Check only one) 2 Medical Examiner: On the basis	of examination and/or in	vestigation, in my opinion, death occurr	red at the time, date a	and place, and due to t	he cause(s)
To the I within 2. To the I complet	×	29b. Signature and title of certifier	(Janha ?	29c. License number	29d.	Date signed (Month, De	ey, Year)
		(Itoward JAUS	· lals)	028792	57	mor	
int		30. Name and address of person who completed cause of					
		31. Date filed (Month, Day, Year) 32. Peri	CnoSSN 049! strar's Signature	2 DAIVE 7414, O	winds Mi	us, my 2	1/17
Sta Registr		31. Date filed (Month, Day, Year) 1 2005 32. Poi	we It A	mente			

			For	State of Maryland			ntal Hygiene	002 10220
		1	- State Registrar		Certificate of		Reg. No.	000 10000
	Dhuninin		. Decedent's Name (First, Middle,			2.	Date of Death Month Day	3. Time of Death
	Physicia /Medic	al			KAINS		MAY 29	
	Examin		a. Facility Name (If not institution, Saint Joseph	give street and number) n Medical Cent		or Location of Death TOWSOF		County of Death Baltimore
	Funeral		Social Security Number 6	Sex 7. Age (In yrs. las	st birthday) If Under 1 Yea Months Day	r If Under 24 Hrs. 8. s Hours Min.	Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country) 9. Macycon?
	Director		Jsual Residence of Decedent	15				10d. Inside City Limits
	arylan show	.	10a. State 10b. County		Town or Location REKVILLE			1 ☐ Yes 2 🗹 No
	the Mi	Funeral Director	10e. Street and Number	MORE /	10f. Zip Code)	10g. Citiz	en of What Country?
	with	<u>a</u> .	TAME REIN	-014 AVE	217	30	(ISA
	ns 23	era	11. Marital Status	12. Was Decedent Ever in U.S	3. Was Decedent o	if Hispanic Origin? (Specifuban, Mexican, Puerto Ric	y Yes or No-	Race - American Indian, Black, White, etc.
36	be filed within 72 hours after death with the Maryland tal Hygiene. Id Hygiene. Id other than "natural", or Items 23a or 28a-f show ed other than "natural", or Items 23a or 28a-f show event, Ite Madical Examirer must be multified at	by Fun	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ N			Specify: WHIF
8	hour tural		15. Decedent's	Education	16a. Decedent's Usual Occ	cupation	16b. Kin	d of Business/Industry
21215-0036	nin 72 In "na Madic	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) Coilege (1-4or 5+)	(Give kind of work dor life. DO NOT use ret	ne during most of working ired)	0	
21	filed with Hygiene. Ither thai	Com		2	ENGINE		First, Middle, Maiden S	SUMMEN
Maryland	ild be file lental Hy rked oth ic event	Be	17. Father's Name (First, Middle, L.	RAIN	.><	MAQU	rist, Middle, Maiden S	KOJRA
7	should be nd Menta marked matic ev	2	19a. Informant's Name/Relationshi		19b. Mailing Address (Stre	eet and Number or Rural F	Route Number, City or	Town, State, Zip Code)
Ma	od 2 s lith an 27 ls r r trau	-	SHIRLEY RAINS		790E B	EVERLY AVE		
	s 1 ar		20a. Method of Disposition	20b. Pla	ace of Disposition (Name of ametery, crematory or other p	Dat (6.3.2	cos -	cation - City or Town, State
E	Page nent c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Specific or Specific or S		DRELAND		HARI	KVILLE, MD
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic en		21. Signatury of Funeral Service I	MOIZZO	00.	dress of Facility EVAN		OF MEMBRIES HILLE, MD 21234
			23a. Part1. Enter the disease, or c	complications that caused the death.		dying, such as cardiac or r	espiratory arrest,	Approximate Interval Between
	Physician	0 11	shock, or heart failure. List of Immediate Cause (Final disease or condition	METASTATIO	C MALIGNANT	MELANOMA		Onset and Death
1	/Medical		resulting in death)	Due to (or as a consequ				
Н	Examiner	L	Sequentially list conditions,	b	roppe of):			
	ed isit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	derice oi).			
•	rate be executed by sician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequ	uence of):			
8760	e be e /siciar e burii	ical E		d				
9	death certificate e attending phys	fedi	10 CC1111 C	1				
Вох	death certifica attending phater afor use as the	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar	death 3 Ectopic pregna		2	23d. Date of delivery Month Day Year
.O. E	the att	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐Unknown	eath 5 ☐ Other <i>(specify</i>	")	5	
Δ.	that the de led by the a detached			ns contributing to death but not resu	ulting in the underlying cause	given in Part I.	23e. Did tobacco u	se contribute to the cause of death?
ds,	uires signe ld be	d by	ACUTE RENAL FAI	LURE			1 ☐ Yes 2	X No 3 Probably 4 □Unknown
Records,	w requir s been si should	lete	SEPSIS				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Re	The law requires that the aate has been signed by the page 2 should be detache	Completed	RESPIRATORY FAI	LURE			performed?	death?
Vital		Be C	25. Was case referred to medical examiner?	DORE		26. Place of Death	Check only one	
1	<u>%</u> ∞ 5	To	1 ☐ Yes 2 🗶 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 ☐ DOA		e 5 Residence	
n of	ding Ph h. After thi funeral		27. Manner of Death 1 X Natural 5 ☐ Pending		Injury	Injury at 28 Work? 1 ☐ Yes 2 ☐ No	3d. Describe how injur	y occurred
Division	or Attending after death. Director: After in by the funer	icat	2 Accident investig	not be 280 Place of laiuny. At ho	ome, farm, street, factory, off		3f. Location (Street an	nd Number or Rural Route Number,
Di≤	al or A after I Direct	Certification:	4 Homicide determi	building, etc. (Specify	y)		City or Town, State	/
	To the Hospital or Attend within 24 hours after death To the Euneral Director: completely filled in by the	edical C	29a. Certifier 1 Certifyin (Check only 2 Medical	g Physician: To the best of my kno Examiner: On the basis of examinal and manner stated.	wiedge, death occurred at the tion and/or investigation, in r	ne time, date and place, ar my opinion, death occurred	nd due to the cause(s) d at the time, date and	and manner as stated. I place, and due to the cause(s)
	o the ithin 2 o the omple	Mec	29b. Signature and title of certifier		111) 29c. Lie	cense number	29d. Dat	te signed (Month, Day, Year)
	⊢ ≯ ⊢ ŏ		Richard	+ Luthicum	D.	31826	5	-29-05
	'n		30. Name and address of person	who completed cause of death (Item	n 23a) (Type, Print)		· · · · · · · · · · · · · · · · · · ·	
	リ	1					SON, MARY	YLAND 21204
	St Regis	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signa UN 0 1 2005	we to for	et le		
	negis	erai	J	AM A T COST CONT	As In lister			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - For Stata Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 250 **Physician** Idella M. Richardson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death City, Town, or Location of Death Examiner N/A sieneral land JaR4 Date of Birth (Month, Day, Year) Nov 19, 1922 9. Birthplace (State or Foreign Country)
S. C. If Under 24 Hrs. 7. Age (In yrs. last birthday 5. Social Security Number Funeral Days Hours 1 □ M 2K□ F Director 219-10-7172 82 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "neturel", or Items 23s or 28e-f show other treumetic event, the Modical Examinar must be notified at 1 Yes 2 No Baltimore N/A Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21217 1520 West North Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Black Specify: 2 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Nursing Home Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. Nurse's Assistant 12 17. Father's Name (First, Middle, Last) Unk Unk 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental H 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 is n 2724 West Edmondson Avenue Baltimore, Maryland 21223 Annette Brogdon Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town. State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State injury or Lansdowne, Md Mt. Zion Cemetery ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Upenses 22 Name and Address of Facility eny Estep Brothers Funeral Service PA 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or com shock, of leart failure. List only complications that caused the defin. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death one cause on each line Sepsi Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner nurla Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit certificate be executed Due to (or as a consequence of) attending physician for use as the burial Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown been signed by The law requires that Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 2∏ No 1 ☐ Yes 2 0 No 1 Yes Division of Vital Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, 3/2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 1 Yes 2 ER/Outpatient 3 DOA 27. Mapher of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide 24 hours a Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Paryland General Hospital death (Item 23a) (Type, Print) m.O 32 Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0 1 2005

ella Richardon

			For Stata Registrar	State of	Maryland / Dep Ce	partment of leartificate of			giene Reg. No.2 0 0 1	18341
	Physicia		1. Decedent's Name (First, Middle, L Dolores Eli	•	lowley			2. Date of Dea Month May	Day Yea 28 2005	
	/Medic Examin		4a. Facility Name (If not institution, ga	ve street and numb	per)	4b. City, Town,	or Location of		4c. County of De	
	ZAGIIIII		C & L Assisted	Living			imore			imore
	Funeral Director		215-18-5032	Sex 7. 1 □ M 2√√ F	. Age (In yrs. last birthda 88 Yrs.	y) If Under 1 Year Months Days		Min. May 22,	1917) Ma	Birthplace (State or Foreign Country) ryland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	72 hours after death with the Maryland natural', or Itams 23a or 28e-f show disal Examinational be motified at	to	Maryland Baltimor	n	Baltimore					1 ☐ Yes 2 ☐ No
	r 28e	Director	10e. Street and Number	C	Darchiore	10f. Zip Code			10g. Citizen of What	Country?
	th wit		1312 Highland Drive				1239		USA	
	tams	Funeral	11. Marital Status	12. Was Deced Armed Force	ent Ever in U.S. 1:	 Was Decedent of If Yes, specify Cul 	Hispanic Orig oan, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
36	s afte	by Fi	1 XXVever Married 2 Married 3 Widowed 4 Divorced	1 □ Yes If Yes, Give Year or Dat		1 ☐ Yes 2 XX No	Specify:		Specify: W	hite
21215-0036	2 hou	ted t	15. Decedent's	Education	16a. Dec	cedent's Usual Occu		- f a di a a	16b. Kind of Busine	ss/Industry
215	within 7, ene. than "na	plet	(Specify only highest g Elementary/Secondary (0-12)	rade completed)	life	ve kind of work done . DO NOT use retire	auring most ad)	of working	_	
7		Completed	12			Clerk	40.34-45-		Insurance	
and	2 should be filed and Mental Hyg is marked other aumatic event,	To Be	17. Father's Name (First, Middle, Las Gilmor Rowley	it)				r's Name <i>(First, Middl</i> e, largaret Schle		
Maryland	12 # Z	-	19a. Informant's Name/Relationship Jane G Rowley					r or Rural Route Numbe timore, Maryl		a, Zip Code)
ē,	of Health of Health fitem 27 r other tra		20a. Method of Disposition			position (Name of rematory or other pl	ace)	Date	20c. Location - City	or Town, State
E			XXX Burial 2 Cremation 3	□ Hemoval from Si :ify)	New Cathe	dral Cemete	ry 6	/1/05	Baltimore,	Maryland
Baltimore,	permit. Pag Department Importent: I eny injury o once.		a Signature of Funer School Lice	Ken K	nakis	22. Name and Addi		Mitchell-Wi York Road Ba		ral Home Inc yland 21212
	/Medical Examiner portion and prival-transit	Examiner	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	a	r as a consequence of): r as a consequence of): r as a consequence of):	hour hve p	G FRT	Failu	le.	Onset and Death
ds, P.O. Box 68760,	es that the death certificate gned by the attending phy: be detached for use as the	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions	1 ☐ Live bir 4 ☐ Pregna 9 ☐ Unknov	nt at time of death wn	3 Ectopic pregnan 5 Other (specify) e underlying cause g				delivery Day Year to the cause of death? Probably 4 Unknown
cor	w requir been si should	letec	1/000					24a. Was	an 24b. Were	autopsy findings available
of Vital Records,	The lav ate has page 2	Completed by						autor perfo 1 🗆 Yes	ormed? death	to completion of cause of n? 'es 2 \(\square\) No
/ita	iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			thor	of Death (Check only o	0.7	1.11
ion of	ding Phys	Mification; To	1 Yes 2M No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of	patient 2 EP/Outpat Unjury 28b. Time (Day Year) Injur	e of 28c. Inj			dence 6 XOther (S how injury occurred	Specify) ASSISTED
Division	al or Atte s after de l Directo d in by th	Celtific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	ed 28e. Place of building	of Injury - At home, farm, g, etc. (Specify)	street, factory, office	Э	28f. Location (City or To		Rural Route Number,
	To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check of 2 Medical Ex	Physician: To the la aminer: On the ba and mann	best of my knowledge, desis of examination and/o er stated.	eath occurred at the r investigation, in my	time, date an opinion, dea	d place, and due to the th occurred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To th To th	3	29b. Signature and total of pertifier	d		29c. Lice	nse number	7	29d. Date signed (M	onth, Day Year)
	1		John /all	flur	(MI)		5/	2405	5/3	1/05
7	V		30. Name and address of person wt	1			MD 3433	10)		/
		ato	Julie Vaughr 31. Date filed (Month, Day, Year)		ch Raven Blvd	Baltimore,	MD 2723	9	/	
	Regist	ate rar	JUN	0 1 2009		I Goard				

		•	State of Marylan	d / Departr		lealth and N	Mental Hy		005	18342
Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last) THOMAS 4a. Facility Name (If not institution, give str.)	ROSEN (BERE	City, Town, or	r Location of Death	2. Date of De. Month	28	Year OS ounty of Death	3. Time of Death 8 15/4 M
Funeral Director	<u> </u>	BALTIMORE REHA 5. Social Security Number 215-03-7275 6. Sex	1311 TATION 7. Age (In yrs.) 88	ast birthday) If	Under 1 Year onths Days	RE BA If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Dec. 16	h y, Year) ,1916	N/A 9. Birthp Cour Mary	place (State or Foreign htty) Land
Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD N/A		y, Town or Location					1	10d. Inside City Limits
with the	Direc	10e. Street and Number 4362 Nicholas Aver			Of. Zip Code 2120	6		-	en of What Cour	ntry?
Interior e., Mar y grant of Z 1 Z 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	by Funeral Director		2. Was Decedent Ever in U. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:			ispanic Origin? (Span, Mexican, Puerto	pecify Yes or No Rican, etc.)	- 14	4. Race - Americ Black, White, Specify: Whi	etc.
vithin 72 hounder.	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4or 5+)	life. DO I	l of work done NOT use retired	during most of wor	king		of Business/In Theatre	dustry
IT Y I ALL IN THE Should be filed within and Mental Hygiene. marked other than imatic event, the Mental I al	To Be Co	17. Father's Name (First, Middle, Last) Thomas Rosenberge	er	ļ Pic	anager	18. Mother's Nam	ne (First, Middle, Dill			
; INICAL YICA and 2 should ealth and Men m 27 Is marke her traumatic		19a. Informant's Name/Relationship (Type Marie Rosenberger-				and Number or Ru S Avenue				
Dattinote, Interpretation of the permit. Pages 1 and 2 Department of Health s Importent: If Item 27 Is any injury or other tra		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Rei 4 □ Donation 3 □ Other (Specify)	20b. F	Place of Disposition temetery, cremator	n (Name of bry or other place	77 7 7 7 7	Date	20c. Loc	ation - City or To	own, State
Daltimor permit. Pages Department of Importent: If II any injury or o		21. Signature of Funeral Service Licenses	Heather Cai		ame and Addre	ss of Facility	eonard			
Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the deat e cause on each line.	h. Do not enter th	ne mode of dyir		or respiratory a	rrest,		Approximate Interval Between Onset and Death
te be executed ysicien and burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequence to (or as a consequence)	uence of):						74.1
The law requires that the death certifica The law requires that the death certifica tie has been signed by the attending ph page 2 should be detached for use as the	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of c	ıl death 3 □Ect	topic pregnanc her (specify)	у		2:	3d. Date of deliv Month	ery Day Year
COLDS, F. w requires that to be been signed by should be detailed.	by P	Part II. Other significant conditions cont	ributing to death but not res	ulting in the under	rlying cause gn	ven in Part I.				the cause of death?
	Completed						24a. Was auto perfo 1 \(\text{Yes}	psy ormed?	prior to co death?	opsy findings available ompletion of cause of
UNISION OF VICAL To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate completely filled in by the funeral director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Autural 5 Pending 2 Accident investigation	ospital: 1 ZInpatient 2 C 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo	ry at	ath (Check only lome 5 ☐ Res 28d. Describe	dence 6		ify)
DIVISION O To the Hospital or Attending Ph within 24 hours after death. To the Funerei Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fy)	, factory, office			Street and wn, State)	l Number or Rur	al Route Number,
Hospite 24 hours Funerei	edical C	29a. Certifier 12 Certifying Physi (Check only one) 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	ation and/or invest	tigation, in my	opinion, death occu	irred at the time,	date and	place, and due t	to the cause(s)
To th within To th	Me	29b. Signature and title of certifier	Hashim	ί.	29c. Licen:	se number	8	29d. Date	signed (Month,	, Day, Year)
Sta Regist	ate rar	30. Name and address of person who con SHER A HAS 31. Date filed (Month, Day, Year) JUN 0 1 2005	mpleted cause of death (Ite	m 23a) (Type, Prir 3 900 ature	LOCH	RAVEN	BLVK	BI	ALTIM	Day, Year) 2005 MD OKE 21278

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	ryland /	•	rtment of F		and M		giene Reg. No.	2005) [343
			1. Decedent's Name (First, Middle, Las	st)						2. Date of Dea Month	ith Day	Year		e of Death
	Physici /Medio		EVELYN	COHE	V	R	ICHMOND			MAY 29	, 20	05	4:3	35 P ™
	Examin		4a. Facility Name (If not institution, give				4b. City, Town, o	r Location o	of Death		4c. (County of De	əth	
	2.4		MANOR CARE NURS						TIMO				N/A	
	Funeral		5. Social Security Number 6. S	ex 7. Age □M 2√2 F	(In yrs. last t	yrs.	Months Days	If Under a	Min.	8. Date of Birtl (Month, Day APR. 23,	Year)	9. Bi	rthplace (Sta. Country)	_
	Director		215-03-1496 1 Usual Residence of Decedent	X	87	113.				APR.23,	1918	3	i	MD
	fand ow		10a. State 10b. County		10c. City, To	wn or Lo	cation				-		10d. Inside	City Limits
	Mary	ō	MD BALTI	MORE		RAI.	TIMORE						1 🗆 Y	es 2 No
	1 the	Director	10e. Street and Number	JOILE		DITE	10f. Zip Code				10g. Citiz	en of What C	ountry?	
	death with the Maryland ms 23a or 28a-f ahow r must Le notified at	0	7 SLADE AVENUE	#115				212	208				USA	P
	death	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. \	Vas Decedent of H	ispanic Orig	gin? (Spi	ecify Yes or No-	1	4. Race - Am		١,
9	or its		1 Never Married 2 Married	1 ☐ Yes 2 🕅 N	0		Yes 2X No	Specify:	i, Fueito	rican, etc./		Black, Wh Specify:	WH]	TC
ğ	hours after tural', or ita	d by	3 X Widowed 4 □ Divorced	Year or Dates:										L L
21215-0036	nati	Completed	15. Decedent's Ed (Specify only highest gra		16	(Give	tent's Usual Occup kind of work done DO NOT use retired	during most	t of work	ing	16b. Kin	d of Busines:	s/Industry	
7	filed within 72 Hygiene. other than "nate ont, the Medic	E C	Elementary/Secondary (0-12)	College (1-4or 5-	+)		EMAKER	2)			OWN	I HOME		
7 0	be filed within 72 hours after death with the Marylan Ital Hygiene. d other than "natural", or Itams 23a or 28a-f ahow event, the Medical Examination mat be notified at	ပို	17. Father's Name (First, Middle, Last)			110111		18. Mothe	r's Name	(First, Middle,				
au		To Be	SAMUEL			KEI:	SER	FST	HER				SCH	HUNICK
Maryland	d 2 should be th and Menta 7 Is marked traumatic ev	-	19a. Informant's Name/Relationship (Type, Print)	19		g Address (Street			al Route Numbe	r, City or	Town, State,		
	nd 2 lith a 27 ls		ALMA BECKER / [DAUGHTER		362	L WOODVAL	LEY D	RIVE	- BALT	IMOR	E, MD	21208	
e,	es 1 and of Healt fitem 2 r other	10	20a. Method of Disposition	D	20b. Place ceme	of Dispo	sition (Name of natory or other place	ce)		Date	20c. Loc	cation - City o	r Town, State)
Baltimore,	Pages nent of ant: If it ary or o		1 🕅 Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		-		HURUN-SOE	1	5/31	/2005	BAL	TIMORE	, MD	
<u>a</u>	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licen	1500	1	and the second	. Name and Addre			L LEVIN).
m	82 = 3		convard (Kunn		3	3900 REIS	TERST	OWN	ROAD -	PIKE	SVILLE	, MD 2	21208
200			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	olications that caused one cause on each line	the death. De e.	o not ente	er the mode of dyin	g, such as	cardiac	or respiratory ari	rest,		Approxir Interval I	mate Between nd Death
y.	Physician		Immediate Cause (Final disease or condition	a. Pr	A Lach	we	Dee	lme					Oliset al	no Dean
3.	/Medical Examiner		resulting in death)	Due to (or as a	consequenc	e of):								
lì	4	ı	Sequentially list conditions,	b. Due to (or as a	emenuence of the second	nte	2							
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate that I in any, cause (Disease or injury	T.	mau									
	be execute sician and burial-trans	xar	that initiated events resulting in death) Last	Due to (or as a										
8/60	sicial s buri	dlcal	(1 Dec	jenza	true	Join	x	D	seare				
9	the death certificate be executed y the attending physician and iched for use as the burial-transit	edle		7)						15.5		I	
XOR	leath certific attending p I for use as	N/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 Live birth 2		th 3	Ectopic pregnancy	,			2:	3d. Date of de	-	
	deat ed for	sicia	in the past 12 months? 1 🗆 Yes 2 🐼 No	4☐Pregnant at t			Other (specify)					Month	Day	Year
J.	at the de s by the a stached	Physician/Me	9 Unknown							00 Ditt				
Ś,	The law requires that ate has been signed b page 2 should be deta	by	Part II. Other significant conditions c	ontributing to death bu	t not resulting	in the ur	iderlying cause giv	en in Part I.			es 2	e contribute		Of death?
Hecords,	w require been sig should b	Completed									95 2			
ပ္	e 2 si	nple								24a. Was a autop	sy	24b. Were a prior to death?	utopsy findin completion o	gs available of cause of
		Co								perfor	2 X No		s 2 No	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth			(Check only or				
Ö		. To	1 Yes 2 No 27. Manner of Death	1Inpatier		Outpatien . Time of	I JU DON	4 (A) 14u1		me 5 Resid			ecify)	
0	ding Ih. Th.	tlon	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year)	Injury	28c. Injur Wor	k? Yes 2 ⊡ N	i					
Division	or Attending after death. Director: After in by the funer	ifica	3 Suicide 6 Could not be		ry - At home,	farm, stre	eet, factory, office			28f. Location (S	treet and	Number or F	lural Route N	lumber,
ā	Dit e	Certification:	4 ☐ Homicide	building, etc.	(Ѕрөспу)					City or Tow	n, State)			
	To the Hospitel within 24 hours a To the Funeral to		29a. Certifier 1 Certifying Ph	ysician: To the best o	f my knowled	ge, death	occurred at the tir	ne, date and	d place,	and due to the c	ause(s) a	and manner a	s stated.	0(c)
	To the H within 24 To the F complete	ledical	one)	and manner stat	ed.	2/10/01 1110			in occum					
	To To	Σ	29b. Signature and title of certifier	2	× 4	5	29c. Licens	314 L		2	esa. Date	signed (Mon	tn, Day, Year	7)
	1		KUM		M	-	- 1				د	1711	0.7	
1	58		30. Name and address of person who	completed cause of de	ath (Item 23a	(Type,	Print) EUTAN	ST	Si	nto ?	R	Bril	t. m1)	2/20
É	Sta	to.	31. Date filed (Month, Day, Year)	32. Registra	Total Control	7	-VITIVU				υ Ψ			
	Registr		IIIN	n 1 bhns	No.	K	Some	P						

			For State Registrar	tate of Marylar		artment of Hotilicate of L		-	giene Reg. No.	005	18344
	Physici	an	Decedent's Name (First, Middle, Last) Harry	L		Sidne	y, Jr.	2. Date of De.	ath Day	200G	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give stre		•	4b. City, Town, or		th May	4c. Co	unty of Death	1 7 474
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. 91	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min			9. Birthpl. Count	
	anyland show	7.	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo					10	od. Inside City Limits
	the M	Director	Md. NA 10e. Street and Number		Balti	10f. Zip Code			10g. Citizen	of What Count	
	h with 23a or	ai Di	5343 Nelson Ave.			2.	1215			USA	
980	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show Acal Exama national be incitiled at	by Funerai	11. Marital Status 12. 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Was Decedent Ever in U Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar t ☐ Yes 🌠 No	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No nto Rican, etc.)		Race - America Black, White, e ecify: B1	
21215-0036	within ene. than "	Completed	15. Decedent's Educati (Specify only highest grade co Elementary/Secondary (0-12) 12th	on <i>mpleted)</i> College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	tion uring most of wo	orking		of Business/Ind	
Maryland 2	be filed tal Hyg d othe evant,	To Be C	17. Father's Name (First, Middle, Last) Harry	S	idney			me (First, Middle, elmeania	Maiden Sui	Downs	
	nd 2 sh lith and 27 Is m r traum		19a. Informant's Name/Relationship (<i>Type</i> , Harriet Middleton	Print) Daughter		ng Address (Street a 3 Rexmere				own, State, Zip (21218	Code)
Baltimore,			20a. Method of Disposition 1 Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State	cemetery, cren	sition (Name of natory or other place e Nat. Ce		Date 1-05		ion - City or Tov	_
Baltir	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	٨	Name and Addres	s of Facility	Ba	ltimor	e, Md. orth Ave	21202	
8760,	Anysician / Medical Examiner physician and physician and the prujar-transit the principle of the properties of the prope	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a consecutive to (or a))).	quence of):	p courd ie	X	el Grun			
.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregn 1 □Live birth 2 □ Fete 4 □ Pregnant at time of o 9 □ Unknown	al déath 3 □	Ectopic pregnancy Other (specify)			23d.	. Date of deliver Month	y Day Year
<u>α</u>	quires that t n signed by uld be deta	by	Part II. Other significant conditions contrib	uting to death but not res	sulting in the u	nderlying cause give	n in Part I.		obacco use		e cause of death?
Vital Records,		Completed						24a. Was autop perfo 1 □ Yes		4b. Were autop prior to com death? 1 \(\text{Yes} \)	sy findings available ipletion of cause of
Vita	Physician: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?	nital:		Othe	P	ath (Check only o			
of	ng ffer inen	tion: To	1 105 22 0	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at Nursing	Home 5 Residence 128d. Describe h)
Division	o Dir	Certification:	a C Suiside 6 Could not be	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str fy)	eet, factory, office	-	28f. Location (S City or Tov	Street and N vn, State)	lumber or Rural	Route Number,
	Hos 24 h Fur stely	edicai (29a. Certifier (Check only one) 1 Certifying Physici 2 Medical Examiner	on: To the best of my known the basis of examination and manner stated.	ation and/or inv	vestigation in my on	inion death occ	urred at the time	date and pla	ce and due to	the cause(s)
	To the within 2 To the comple	W	29b. Signature and title of certifier	(soin)	29c. License	P956		May	igned (Month, D	2) 21239
/	XX.	2	30. Name and address of person who comp	leted cause of death (Item	n 23a) (Type,	h Rave	n Blvd	, Balo	himor	emi	21239
	Sta Registr		31. Date filed (Month, Day, Yound)	2 Par pgistras Sign	ature	Spark	•				

		1	For State of Ma		partment of H			giene 005	18345
			Decedent's Name (First, Middle, Last)				2. Date of Dea	ath	3. Time of Death
	Physicia	ın	Catherino SCHAEFE	R			Month 05	ZS OS	1:45 PM
	/Medic Examin		la. Facility Name (If not institution, give street and number)	/	4b. City, Town, or	Location of Death		4c. County of Dea	th
4	Examin	er	ANNE ARUNDEL MEDICAL CE	NTER	Annapo1	ie		Anne Aru	nde1
	Funeral		i. Social Security Number 6. Sex 7. Age	(In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day		thplace (State or Foreign
	Director		214-38-6105 1DM 28F	94 Yrs.	Months Days	Hours Min.	7/2/19		yland
	P .		Usual Residence of Decedent	10- 0'h T-	Lastina				10d. Inside City Limits
	show	_	10a. State 10b. County	10c. City, Town or	Location				1 ☐ Yes 2 ☒ No
	Ba-f s	Director	MD Anne Arundel	Arnold					
	ith th	吉	10e. Street and Number		10f. Zip Code			10g. Citizen of What Co	
	ath w 23a	<u>a</u>	875 Doris Drive		21012			United Stat	
	tems	nne	11. Marital Status 12. Was Decedent E Armed Forces?		 Was Decedent of His If Yes, specify Cuba 	ispanic Origin? (Spec in, Mexican, Puerto P	offy Yes or No- lican, etc.)	- 14. Race - Ame Black, Whi	
36	s afte	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No 1 ☐ Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates:	,	1 ☐ Yes 2 No	Specify:		Specify:	White
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Merital Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examinat must be notified at		15. Decedent's Education	16a. Dec	cedent's Usual Occupa	ation		16b, Kind of Business	/Industry
갻	n 72	Completed	(Specify only highest grade completed)	(Gi	ve kind of work done o . DO NOT use retired	during most of workin	g		
12	within than "	E	Elementary/Secondary (0-12) College (1-4or 5-	Hon	nemaker			Own Home	2
	2 should be filed within and Mental Hygiene. is marked other than raumatic event, it a Me		17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle,	Maiden Sumame)	
an	id be ental ked o	To Be	Henry George Wagner			Matild	a Maue	rhan	
Maryland	shound M	-	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	iling Address (Street a			er, City or Town, State,	Zip Code)
Z	od 2 Ith al 27 is		Gilbert Schaefer / son	875	Doris Dr	ive Arnold	. Mary	land 21012	
5	ss 1 and 2 of Health of Item 27 i	- 1	20a. Method of Disposition	20b. Place of Dis	position (Name of rematory or other place	Da	ate	20c. Location - City or	Town, State
9	ages ant of t: If I		1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)		Park Cemet		2005	Baltimore,	Maryland
Baltimore,	permit. Pages Department of Inportant: If Ite any injury or of	1	21. Sign to e of Fune a Service License	1				neral Home	
Ba	Departing once		NOON 2 NOW		1328 Sulph	ur Spring	Rd. Ba	altimore, M	D 21227
	_		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do not a	enter the mode of dyin	g, such as cardiac or	respiratory ar	rrest,	Approximate
	=1								Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	CE LUNG	GESTIVE (MINIAC F	AKUI	C.C.	
	Examiner		C 0 0		OPATHY				
		ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a	consequence of):					
_	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c						
, <u>,</u>	be executed ician and burial-transif	Exa		consequence of):					
1760	ate be executed hysician and the burial-transit	cal	d						
68	ificat g phy as th							T	
Вох	leath certifical attending phy I for use as th	by Physiclan/Med	IF FEMALE: 23c. If yes, outcome of the big big big big big big big big big big		2 DEctorio arganana	,		23d. Date of de	•
m	death	icla	in the past 12 months?		3 □Ectopic pregnancy 5 □ Other (s <i>pecify</i>) _			Month	Day Year
0	that the der	hys	9 Unknown						
٦,	requires that the peen signed by th hould be detache	y P	Part II. Other significant conditions contributing to death but	t not resulting in the	underlying cause giv	en in Part I.	23e. Did t	obacco use contribute t	o the cause of death?
rds	quire nn sig uld b		CHRONIC ATRIAL FIBRI	LLATION	<i>J</i>		10	Yes 2. No 3□P	robably 4 Unknown
Records,	> 11 0	Completed	URINARY TRACT INF	ECTION	/		24a. Was	an 24b. Were a	utopsy findings available completion of cause of
Re	9 4 9	E	RENAL INSUFFICIE					ormed? death?	5 /
Vital	iclan: Th certificate rector, pag	0	25. Was case referred to medical	001		26. Place of Death	_	/	7
5	Physician: r this certific ral director,	0 B	examiner?	nt 2 ER/Outpat	tient 3 DOA Oth			dence 6 Other (Spe	ecify)
ō	ding Phy h. After this funeral o	n: T	27. Manner of Death 28a. Date of Injur	v 28b. Time	e of 28c. Injur			how injury occurred	
Division	Attending In death. ector: After by the funer	Certification;	1 Natural 5 Pending (Worth, Day 2 Accident investigation	Year) Injur		Yes 2 □No			
Vis.	Attendi r death. ector: A by the fu	ifle	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inju	ry - At home, farm,	street, factory, office	2	8f. Location (: City or Tox	Street and Number or F	lural Route Number,
ā	a afte	ert	a Fromeida bullaring, etc	. (Specify)		1	0.1, 0. 70.	m, otato,	
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	al (29a. Certifier (Check only (Ch	f my knowledge, de	eath occurred at the tir	me, date and place, a	nd due to the	cause(s) and manner a	s stated.
	the Ho hin 24 I the Fu npletel	ledical	(Check only 2 Medical Examiner: On the basis of one) and manner sta		i investigation, in my c	pinion, death occurre	at the time,		
	vithir To th	×	29b. Signature and title of certifier		29c. Licens	se number		29d. Date signed (Mon	th, Day, Year)
	/		Tolog toro Laure	sia M	D 104	1034		05-25	-05
	ń		30. Name and address of person who completed cause of de	eath (Item 23a) (Ty		-			443-481-1000
			SALVATORE LAURIA 128 LUB	RAND DRI	VE SUITE 3	BOO, ANNI	POLIS.	MD 2140)
	St	ate		ar's Signature	à	h a			
	Regist	rar	JUN 0 1 2005	MARINE	It board	الم			

			1 - For State of Maryland / D	epartment of He			iene 005	18346			
	Physici		1. Decedent's Name (First, Middle, Last) James Franklin Saunders			2. Date of Death Month May		3. Time of Death 6:20 a ^M			
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Villa St. Michael Nursing Home	4b. City, Town, or L Baltimo:			4c. County of Dea				
	Funeral Director		5. Social Security Number 219-40-4368 6. Sex 1 ★ M 2 □ F 61 Y	nday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 06-30-19	9. Bir 943 Ma	thplace (State or Foreign buntry) ryland			
	show	'n	Usual Residence of Decedent 10a. State					10d. Inside City Limits			
	with the M. s or 28e-1	Director	10e. Street and Number 4800 Seaton Drive	10f. Zip Code 21215		10	Og. Citizen of What Co	ountry?			
920	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "neturel", or Items 23s.or 28e-1 show event. The Medical Examinar must be multiled at	by Funeral	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	13. Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2X No	panic Origin? (Spe , Mexican, Puerto I Specify:	ocify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit				
Maryland 21215-0036	within 72 hound no. I how "neture then "neture to be Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Sepondary (0-12) College (1-4or 5+) Sal	Decedent's Usual Occupat Give kind of work done du life. DO NOT use retired) Les Clerk	tion uring most of worki	ng 1	Sales	/Industry			
land 2	be filed ital Hygi id other event.	To Be Co	17. Father's Name (First, Middle, Last) William F. Saunders		18. Mother's Name Alta M	(First, Middle, M larie Eva					
	12 sh h and 7 Is m traum	 	19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street ar 202 Leeds Av		Route Number,	City or Town, State, .	Zip Code)			
Baltimore,	Pages nent of ant: If it		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify)	Disposition (Name of crematory or other place,	06-01		20c. Location - City or Baltimore,				
Balt	permit. Departr Imports eny inju		21. algnature of Funeral School License e	neral Hon ur Spring	Rd. A	rbutus, MD	. 21227				
100	Pnysician		23a. Part I. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	7	, such as cardiac o		est,	Approximate Interval Between Onset and Death			
100	/Medical Examiner		resulting in death) Due to (or a la consequence) Sequentially list conditions,	el de	sity						
8760,	be executed sician and burial-transit	al Examiner	Sequentially list conditions, than, Lading to the todate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Liebelee Due to (or as a consequence of): Due to (or as a consequence of):								
.O. Box 687	death certificate le attending phys ed for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of de Month	livery Day Year			
S, D	signed d be de	by	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause giver	n in Part I.		s 2 No 3 P	o the cause of death?			
Il Record		Completed				24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of 2 2 3 No			
Vital	9 9	o Be	25. Was case referred to medical examiner?	Other	26. Place of Death		e) nce 6 □Other (Spe	nife)			
of	ing After une	Per		me of 28c. Injury			w injury occurred	City)			
Division	tel or Attend rs after death al Director: /	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	m, street, factory, office	2	28f. Location (Str. City or Town,	reet and Number or Ri , State)	ural Route Number,			
	To the Hospitel or Ati within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	/or investigation, in my opi	nion, death occurre	ed at the time, da	ite and place, and due	e to the cause(s)			
)	5 with	Σ	29b. Signature and title of certifier	29c. License	142J	29	d. Date signed (Mont	n, Day, Year)			
	59		30. Name and address of person who completed cause of deal (Item 23a) (1	413 COMM	nonvie	eotter,	MD cat	onsville, un			
	Sta Registi		JUN 0 1 2009 Legger	to Sperke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last) Month Day Vaar Physician 204 1 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number, Examiner Baltimore baltimore bal If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 1 M 2 F **Funeral** Months Hours Davs Director б 18 192 MARYL Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show other traumatic event, the Medical Examiner must be nutified at 1 Yes 2 No Director eda DALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21237 or Itams 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married ☐ Yes 2 No Yes, Give 1□ Yes 2K No Baltimore, Maryland 21215-0036 Specify: Specify: White 3 Widowed 4 Divorced "natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be nee Hele loud ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informan 's Name/Relationship (Type, Print) 2123 item 27 MONX 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 10 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) ò permit. Page Department of Important: If any injury or once. 6-05 0-21. Signature of Funeral Service Licensee 21230 22. Name and Address of Facility ORD MD FUNERAL CHAPEZ 23a. Part1. Enter the disease, br complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Ischemke Bowel 3 days /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): P.O. Box 68760 Physician/Medicai the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Day in the past 12 months? 1 ☐ Yes 2 🛣 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by congestive Heart Follore Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Chronic Disease Diabetes autopsy performed 20**%**10 Abrilla non Atrial 2 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After t 5 Pending investigation death. 1 🗌 Yes 2 □ No after death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai 29a Certifier

24 hours a within 2

> State Registrar

4940

29b. Signature and little of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eastern 32. Registrar's Signature 31. Date filed (Month, Day, Year)

JUN 0

M.D.

2005

Md Baltmare

29c. License number

RES-000

21724

29d. Date signed (Month, Day, Year)

5-28-2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) Month **Physician** 00 PM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner Birthplace (State or Foreign Country) If Under 8. Date of Birth (Month, Day, 6. Sex 7. Age (In vrs. last birthday) 5. Socia **Funeral** Months Min. Hours 1 ☐ M 2 🖫 F Days Director the Maryland 10d. Inside City Limits 10a, State 10b. 10c. City, Town or Location treumatic event, the Madical Examinary ust be notified at 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code. 10g, Citizen of What Country? C or items 23e Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -American Indian, 11. Marital Status Black, White, etc. 22 Married 2 No 1 Never Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: 3 - Widowed 4 Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within in and Mental Hygiene. 7 is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be aller 19th, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) tore 19a. Informant's Name/Relationship (Type, Print) mo 21206 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) other Baltimore, Date 20c. Location - Ity or Town, State 20a. Method of Disposition Pages 1 tment of F Department of Importent: If it eny injury or o 1 Burial 2 Cremation 3 □Removal from State une 3 1 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Peaceful Alternative and cumaning YORK rd. TIMONIUM, MD 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ML disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year for Month Day in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknows Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 1 Tyes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wasan page 2 autopsy 2 No 1 Yes To the Hospitel or Attending Physicien: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 JN0 Other: 6 Other (Specify) 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Certification; To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury 27. Manner of D 28b. Time of 28c. Injury at Work? occurred After Natural 5 Pending investigation М 1 Tyes 2 □ No death. 2 Accident after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide filled 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number title of certifier 29b. Signature and 30. Nan dress of person who completed cause of death (Item 23a) (Type, Print) no MALES 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month 2005 Year 27, May JOHN EDWIN SOLLOWAY, JR. 12:35 am^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 1 ∰ M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Yrs. 1917 Director July 14, Maryland 87 <u>215-10-4339</u> Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits r Itams 23a or 28a-1 show if er coust be notified at 1 ☐ Yes 2 X No Funeral Director Maryland Anne Arundel <u>Glen Burnie</u> 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21061 United States 518 Kintop Road filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Dyes 2 No
If Xes, Give
Year or Dates: 1939-69 1 Never Married 2X Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 ☑ No Specify: Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Fleet Reserve United States Navy 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Is marked c Maud Emma Ottinger John Edwin Solloway, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 518 Kintop Road Glen Burnie, MD 21061 19a. Informant's Name/Relationship (Type, Print) 518 Kintop Road Glen Burnie, MD Margaret D. Solloway (wife) Health at tam 27 l itam 2 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ò 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 14 □ Donation 5 □ Other (Specify) 5-31-2005 Baltimore, Maryland Bayview Crematory 21. Signature of Fune ^{22. Name and} Address of Facility McCully-Polyniak Funeral Home, 237 E. Patapsco Ave. Baltimore, ervice Licensee 21225 mocgzz 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Physician neart disease or condition resulting in death) /Medical Examiner Stenosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of). P.O. Box 68760, Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by page 2 should be Disear 1/XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2XNo certificate 2**X** No 1 ☐ Yes 1 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To tha Funeral Director: A investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) tha 29b. Signature and til e of certifier 29c. License number 29d. Date/signed (Month, Day, Year) 27 20+1 and address of person who completed cause of death (Item 23a) (Type, Print) 40 0 31. Date filed (Month, Day, Year) Registrar's Signature State ENGLAS. Registrar

			i lease i	State of Maryland				-	giene	
		•	1 - For State Registrar	olato of marytains		tificate of			Reg. No. 2 0 0 1	5 + 18350
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day Yeer	3. Time of Death
	Physicia /Medic		Mary	B.		5	drick	May	25,200	a la maria de M
	Examin		4a. Fecility Name (# not institution, give st	reet and number)		4b. City, Town, o		ath (4c. County of De	eth
H			Bayyien Med		at birth days	If Under 1 Year	If Under 24 Hr	S R Date of Rie	N/A	inthology (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. la	Yrs.	Months Days	Hours Mir		(, Yeer)	irthplace (State or Foreign Sountry) aryland
			Usual Residence of Decedent	0-7			1	1.17-1-1	72322 110	
	rylan show	_	10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2★☐ No
	8a-fs	Directo	Maryland Baltim	ore		1	Du	ndalk	40-02	
	with ti		10e. Street and Number 7511 Berkshire R	024		10f. Zip Code	21	224	10g. Citizen of What C United S	
	be filed within 72 hours after death with the Maryland ale Hygiene. Ale Hygiene of the than "natural", or flems 23a or 28a-f show other than "natural", or flems 23a or 28a-f show event, the Medical Examinar must be notiliad at	Funeral		2. Was Decedent Ever in U.S	5. 13.	Was Decedent of H		(Specify Yes or No- erto Rican, etc.)		nerican Indian,
٩	after or fter	Fun	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No	1	if Yes, specify Cub; 1 ☐ Yes 2 ☒ No		erto Rican, etc.)		ite, etc.
9	hours after tural', or ite al Exemina	d by	3 ☐Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:					Specify:	White
<u>.</u>	"natu	Completed	15. Decedent's Educa (Specify only highest grade		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of w	orking	16b. Kind of Busines	s/Industry
7	filed within 72 Hygiene. sther than "nate ont, the Medic	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)		Homemaker			Own_H	(ama
2	filed withi I Hygiene. other than	Be Co	12 Years 17. Father's Name (First, Middle, Last)			10 memarer		ame (First, Middle,		ome
<u>a</u>		To B	Joseph T. Rohle	der			Anı	nette M.	Tellis	
Maryland 21215-0036	and and is m		19a. Informant's Name/Relationship (Typ						ar, City or Town, State,	Zip Code)
	1 and 1 Health Iem 27 other tr		Mr. Dennis C. Smith			4 Placid	Ave. Ba	altimore,	Maryland 20c. Location - City of	21234
Baltimore,	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	emetery, crei	natory or other place	1			
			*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licenses			of Faith 2. Name and Addre				, Maryland
B	permit. Departimopartim		arrecon E	Keen	Di	ida-Ruck	Funeral	Home of	Dundalk, I Maryland	nc.
			23a. Part1. Enter the Asease, or complic shock, or heart failure. List only one	ations that caused the death	. Do not ent	er the mode of dyir	ng, such as cardi	ac or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Respira	ton s	Acre				Onset and Death
π	/Medical		resulting in death)	Due to (or as a consequ	ience of):					
36	Examiner	L	Sequentially list conditions b.	Precumot Due to for as a consequence		. X				
	led sit	Examiner	fi any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a consequ	2.126	Ci no				
	al-trai	xar	that initiated events c. resulting in death) Last	Due to (or as a consequ		25101.1				
760,	e be executed /sicien and e burial-transit	cal	d	Pieuma	via_					
89			IC CEMALE.							
Вох	death certifica e attending ph id for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetel	death 3[Ectopic pregnanc	y		23d. Date of d Month	elivery Day Year
о. П	O O	sicl	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐ Unknown	ath 5	Other (specify) _			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Duy / Ju.
<u> </u>	The law requires that the de ate has been signed by the page 2 should be detached	by Physiclan/Med	Part II. Other significent conditions cont	tributing to death but not resu	ılting in the u	nderlying cause giv	ven in Part I.	23e. Did to	obacco use contribute	to the cause of death?
Records,	uires sign		-					101	res 2 🛣 No 3 🗆 I	Probably 4 DUnknown
00	s beer shou	Completed						24a. Was		autopsy findings available
	The lay te has age 2	mo							rmed? death?	
Vita		Be C	25. Was case referred to medical examiner?				26. Place of D	eath (Check only o		
<u>></u>	Physic this ce al direc	To	1 ☐ Yes 2 🔀 No		ER/Outpatier	II 3L DOA	_		dence 6 Other (Sp	pecify)
n O	ing Ph After th uneral	lon:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time o Injury	Wo	rk?	28d. Describe h	now injury occurred	
Division of	r Attending Per death. rector: Atter to by the funera	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	me farm st		Yes 2 □ No	28f. Location (5	Street and Number or I	Rural Route Number.
<u>≤</u>	after Direction by	Certification:	4 ☐ Homicide determined	building, etc. (Specify				City or Tov		
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director,			ician: To the best of my know						
	he Ho in 24 I he Fu pletel	edical	(Check only 2 Medicel Exemin one)	er: On the basis of examinat and manner stated.	tion and/or in					
1	To the within 2 To the complete	Σ	29b. Signature and title of certifier	_01		29c. Licens			29d. Date signed (Moi	
	n of		30. Name and address of person who bor	zall	M.T	J. AF 21	064200	- K392	May 26	12005
	L		Su. Name and address of person who cor	Kin HGHM		4620 F	NO 12	x Him	May 26	PCCIC
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signat	tupe and a		41.		10 111	
	Registr	ar	TUN U 1 2005 🎤	90 mm 18 16	TOBALL!					

		1	For Stata Registrar		aryland /		artment of H				Reg. No.	2005	18351
ı	Physici /Medic	an	Decedent's Name (First, Middle, Last Margaret M. Shannon							2. Date of De. Month May 26,		Year	3. Time of Death 1:45 Р м
	Examin	er	4a. Facility Name (If not institution, give 8723 Roper Road				4b. City, Town, or Parkville					Baltimor	·e
	Funeral Director		220 10 3001		e (In yrs. last bi 79	rthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bird (Month, Da October	1, 19	9. Bir	thplace (State or Foreign ountry) Cland
	Maryland a-f show		Usual Residence of Decedent 10a. State 10b. County Maryland Baltimo	re	10c. City, Tov Parkvi		cation						10d. Inside City Limits 1 ☐ Yes 2 🂢 No
ı	h with the	Funeral Director	10e. Street and Number 8723 Roper Road				10f. Zip Code 21234	-				en of Whal Co USA	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mental Hygiene. Important: If item 27 is marked othar than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ira Medical Eva nicel must be ricitled at Once.		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 Y If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Ori an, Mexicar Specify:	gin? (Spec i, Puerto R	cify Yes or No lican, etc.)		4. Race - Ame Black, Whit Specify:	
21215-0036	i within 72 ho pene. r than "natur rre Medical	Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)			(Give life.	dent's Usual Occup kind of work done o DO NOT use retired Homemaker	ation during mos	t of workin	g		d of Business Home	/Industry
land	id be filed ental Hyg kad othal ic event,	To Be C	17. Father's Name (First, Middle, Last) Andrew P. Behan		·				er's Name Conner	(First, Middle, ton	, Maiden S	Surname)	
Maryland	nd 2 shou lith and M 27 Is mar r traumat	-	19a. Informant's Name/Relationship (7 Andrew J. Shannon/Hust				ng Address (Street a			Route Number	er, City or 21234		Zip Code)
altimore,	Pages 1 and the source of Hest of Hest of Hest out: If item iry or other		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ ↑ 4 □ Donation 5 □ Other (Specify		cemete	ery, crer	sition (Name of matory or other place emetery	же)	5/31/0	ate 05		eation - City or more Mar	
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Licen-	See Christina	L. Hilto	- 13	Name and Addre Conard J. R 305 Harfurd	ss of Facility UCK, I	nc. Balti	more Mar	yland	21214	
THE STATE OF	Physician /Medical Examiner and the prirat-transit	Examiner	23a. Part1. Enter the disease, or compands, or heart failure. List only of limediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ACUTE Due to (or as b. Due to (or as HYPE C.	MYOCA	1x0/ of): xxe oi).	er the mode of dyin AL INFA RY DISON	RCTTO		respiratory a	rrest,		Approximate Interval Between Onset and Death
O.	the death certific y the attending p iched for use as	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	d	2 Fetal deat		Ectopic pregnancy Other (specify)	,			2	3d. Date of de Month	livery Day Year
of Vital Records, P.	fhe law requires the te has been signed age 2 should be de	ompleted by	Part II. Other significant conditions of	ontributing to death t	-					1 🗆 24a. Was auto	Yes 2	No 3 P	o the cause of death? robably 4 Donknown utopsy findings available completion of cause of
Vital	siclan: certifica rector,	o Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 ER/C	lutnatio	nt 3 DOA Oth	OF.		(Check only o		Other (Spe	acity)
ivision	or Attending ter death. iractor: After n by the fune	Certification; T	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	28a. Date of Inj (Month, Da	ay Year) 28b.	Time o	f 28c. Injur Wor M 1		No 2	8d. Describe 8f. Location (City or To	how injury Street and yn, State)	occurred	ural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical Ce		ysician: To the best niner: On the basis of and manner s	of examination a		h occurred at the tir			nd due to the			
)	To the within 2 To the comple	Med	29b. Signature and title of certifier Acres L Nolo		lated.		29c. Licens					e signed (Mon	
	10		30. Name and address of person who	completed cause of	death (Item 23a) (Type,	Print)	21200	4				
*	St Regist	ate rar	30. Name and address of person who PF31 SAFFRE HILL 31. Date filed (Month, Day, Year) JUN 0 1 2005	32. Regist	rar's Signature	nest!	2)						

amend item/19 Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** STEPHEN EDWARD TOWNES JR. 07:40 AM May 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 5. Social Security Number Bellmore Baltmarc Ctm 7. Age (In yrs. last birthday) 55 yrs If Under 1 Year If Under 24 Hrs. 8. Date of Birth 08/25/1949 Funeral 6. Sex XXM 2□F 9. Birthplace (State or Foreign Months Days Hours NEW YORK 074-42-0669 Director Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits iral', or Itams 23s or 28a-f show Examiner must be notified at MD N/A BALTIMORE CITY XXYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 6929 REISTERSTOWN ROAD 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★★No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 and 2 should be tiled within 72 hours atter. Health and Mental Hygiene. em 27 Is marked other than "natural", or Ital wither traumatic event, the Medical Examinal 1 Never Married 2 Married 1 ☐ Yes XX No Specify: BLACK þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DIETARY AIDE HARBOR HOSPITAL CENTER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be STEPHEN EDWARD TOWNES, SR. MODELIA THOMPSON 19b. Mailing Address (Street and Number or Rural Rome Yumber, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6929 REISTERSTOWN ROAD, BALTIMOR#E, MD 21215 PHILLIP M. TOWNES / BROTHER tem 20a. Method of Disposition

A Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o ö 6/4/05 MT. ZION CEMETERY 5 ☐ Other (Specify) BALTIMORE CO., MD ^¹ 4 □ Donation un rai Service Licenses 22. Name and Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD 21207 er the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme ia Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Lands Mct.stic Colon Adensevens Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and the burial-transit The law requires that the death certiticate be executed Due to (or as a consequence of) Box 68760. Physician/Medical attending for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 ∭Linknown IL Monkres 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? certificate 2 No 1 TYes Division of Vital director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Cther: 4 Nursing Home 5 Residence 6 Other (Specify) ۴ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending | within 24 hours after death. To the Funeral Diractor: Atter 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D. 0 RES-000 M., 28, 2005

Registrar

State

145,241

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mrston

0 1

31. Date filed (Month, Day,

	1- For Amend Item 20b per in G844 6-22 05 tas of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 1 1 1 1 20 1 1 20 1 1 1 1 20 1 1 1 1
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 2145 M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4c. County of Death 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
Funeral Director	213-72-7867 19XM 2 F 47 Yrs. Months Days Hours Min. 0 9971 87 1957 TEXAS Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
with the Mar or 28a-fs be notified Director	MD HOWARD COLUMBIA 109. Street and Number 106. Zip Code 109. Citizen of What Country?
5-0036 72 hours after death v natural; or Items 23s iten Evaninar must	11. Marital Status
Maryland 21215-01 12 should be filed within 72 hon and Mental Hygiene. 7 is marked other than "natura raumatic event, the Medical strumetic Be Completed	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Maryland 42 should be file th and Mental Hy 77 Is marked oth traumatic even To Be (ROOSEVELT TENNESSEE 19a. Informant's Name/Relationship (Type, Print) BETTY L. TENNESSEE / WIFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6127 JERRY'S DRIVE, COLUMBIA, MD 21044
Baltimore, Ma permit. Pages 1 and 2: Department of Health at Important: If item 27 is any injury or other trai	20a. Method of Disposition 1 \(\text{Burial 2 \(\text{Cremation 3 \(\text{Removal from State} \)} \) 20b. Place of Disposition (Name of MD Condition 1) (Name of MD Condition 1) (Name of MD Condition 2) (Name of MD Condition 3) (Name of MD Co
Baltin permit. F Departm Importar any injur	21. Signature Tryheral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEICHTS AVENUE, BALTIMORE, MD
death certificate be executed death certificate be executed e attending physician and ed for use as the burial-transit electrical examiner	23 Mant Epter the sease, or complications that caused the deal. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 3 DAYS ACUTE MYOCARDIAL INFARCTION a. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):
death certifications of for use as iclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
be of be	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
The law requires that the rate has been signed by the page 2 should be detache.	HYPERLIPIDEMIA 24a. Was an autopsy performed? prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
ysician ysician s certifii director	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
trending death. ctor: After the funerication	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 No 28d. Describe how injury occurred
DIV To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by Medical Certif	29a. Certifier (Check only (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
/	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)
State Registrar	CHARLES FRANKLIN, M.D. 11120 NEW HAMPSHIRE AVE, SILVER SPRING, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature 1 2005

Larry Tate 05-03657 NJM

57		Sta 1 - State Unpend Item 23a,	te of Maryland pt.II,27 pe	d/Depa er me Cei	artment of H G844 6-15 dificate of L	ealth an 205 £a Death	d Mental	Hygiene	.200		loor
Physic /Medi		Decedent's Name (First, Middle, Last) LARRY D • TATI	Ξ.				2. Date Mont May	of Death h Da 2		ar	ime of Death
Exami		4a. Facility Name (If not institution, give street a 104 Carver Road		and hirthday	4b. City, Town, or Turner:		Lon]	. County of E	ore	State or Forei
Funeral Director		5. Social Security Number 212-60-4924 Usual Residence of Decedent	7. Age (In yrs. la	Yrs.	Months Days		din. (Mon	h, Day, Year) 26–196		Country)	MD
e Maryland Sa-f show	ctor	10a. State 10b. County MD BALTIMORE		Town or Lo	cation S STATION					1 [side City Limit XYes 2 □ N
with the	Dire	104. CARNER BOAD			10f. Zip Code 212	2.2		10g. Ci	tizen of What USA	t Country?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumetic event, the Modical Extra interioral be notified at any injury or other traumetic event, the Modical Extra interioral be notified at any injury or other traumetic event.	by Funeral Director	XXNever Married 2 Married 1	as Decedent Ever in U.S ned Forces? Yes XXNo 'es, Give ar or Dates:		Was Decedent of Hill Yes, specify Cuba		? (Specify Yes uerto Rican, et	or No- c.)	14. Race - A Black, V	American Ind Vhite, etc.	lian,
within 72 hou ene. than "natura	Completed	15. Decedent's Education (Specify only highest grade comp		(Give life.	dent's Usual Occupa kind of work done o DO NOT use retired	durina most of	working		16b. Kind of Business/Industry JOHNS HOPKINS—BAYVIEW		
ld be filed ental Hygi ked other ic evant.	To Be Co	17. Father's Name (First, Middle, Last) DONALD TATE		11003			Name (First, M	liddle, Maider		11110	
2 shou and M is mar	-	19a. Informant's Name/Relationship (Type, Pr. LISA GRIFFIN/SISTER	int)	19b. Mailir	ng Address (Street a					te, Zip Code,)
tand Health tam 27 other to		20a. Method of Disposition	20b. PI	lace of Dispo	MARLORA esition (Name of		ALT IMOR Date		YLAND ocation - City	21239 or Town, Si	
Pages nent of ant: If i		1 X Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)			matory or other plac NISLAUS C		-4-2005	BA	LTIMOR	E, MAI	RYLAND
Departri Departri Imports any inju	21. Signature of Funeral Service Licensee 22. Name and Address of Facility JA 1701-31 LAURENS S 23a. Page. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac							. MORT			-
hysician and purisitions the burial-transit sthe burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Clease of Clease	Cute Epiglo Due to (or as a consequ Due to (or as a consequ Due to (or as a consequ	uence of):	5						
death certif e attending od for use a	Physician/Med	in the past 12 months?	res, outcome of pregna □Live birth 2 □Fetal □Pregnant at time of de □Unknown	death 3[⊒Ectopic pregnancy □ Other (specify)				23d. Date of Month	delivery Day	Year
5 5	by	Part II. Other significant conditions contributions Hypertensive Cardiova	-	-	nderlying cause give	en in Part I.	23e.	Did tobacco		e to the cau	se of death?
	Completed						_	Was an autopsy performed?	prior deat	to/completion	ndings availab on of cause of
ding Physician: Th h. After this certificate funeral director, pag	tion: To Be	1 XNatural 5 🖸 Pending	ll: 1 ☐ Inpatient 2 ☐ 1 L. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	Worl	er: 4 □ Nursi	Death (Checking Home 5 28d. Des			Specify) S	cene
or Attending after death. Director: After d in by the fune	ertification:	2 Cuiside 6 Could not be	Place of Injury - At ho building, etc. (Specify	ome, farm, st				tion (Street ar or Town, State		r Rural Rout	e Number,
vithin 24 hours after or Ar To the Funeral Directory completely filled in by	edical C	29a. Certifier 1 Certifying Physician (Check only one) 1 Medical Examiner: O at									ause(s)
withir comp	Me	29b. Signature and title of certifier Description Des	Sale W)	29c. License OCME				9d. Date signed (<i>Month, Day, Year</i>) May, 28, 2005		
Cy		30. Name and address of person who complete HAMA MAN A. (CO)	254		111 Per	n Stre	et Bal	timore	, Mary	land	21201
St Regis	tate trar	31. Date filed (Month, Day, Year)	32. Registrar's Signal	ture	Sports						

Alphonso Taylor Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-03330 NJM 1- For Unpend Item 23a,27,28a-f per me G244 6-3-05 Las
Red. No.
Red. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** May 2005 2020 Alphonso Taylor /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 819 North Carey Street Baltimore City Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ₹ M 2 □ F Yrs. Director 220-76-6394 48 Jan Maryland Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r Items 23a or 28a-f show ingravest be notified at 1√ Yes 2 No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, tra Medical Examer research 21216 819 N. Carey Street USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: black. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education unk (Specify only highest grade completed) janitorial Elementary/Secondary (0-12) College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Viola Epps 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Wilson/friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 □Donation 5 🖾 Other (Specify) in state 21. Sign to Funeral Service Lice 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Ronald Baltimore, MD nin Approximate from the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line.

Asphyxia Due To Plastic Bag Over Head And Methane Inhalation 23a. Part 1 Enter the disease, or con-shock or heart failure. List only Interval Between Onset and Death Immediate dause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dua to (or se a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): ending physician a use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1. ★ es 2 □ No 24a. Was an autopsy performed? page 2 certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Scene Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 1 XYes 2 No Poundh, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred **Subject put** plastic bag over head and 27. Manner of Death Certification: Found 8:20 1 Natural 5 Pending death. 1 ☐ Yes 2 ▼ No investigation Accident 5-13-05 connected a pipe to natural gas 28f. Location (Street and Number or Rural Route Number, City or Town, State) 819 N. Carey Street after deatl Director: 6 Could not be determined 3 X Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ò 4 Homicide

Box 68760 P.0. Division of Vital Records, Hospital or Attending Physician:

City of Town, State) 819 N. Carey Street Baltimore, Md Scene 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

OCME

May, 14, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street Baltimore, Maryland 21201

unk

Registrar

Medical

31. Date filed (Month, Day, Year)

32. Registrar's Signature

JUN 0 1 2005

24 hours a Euneral f

within 2

		State of Maryland / Department of Health and Mental Hygiene 1 - Stete Registrar Certificate of Death Reg. No. 2 1 1 2 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2									
	Physici /Medic		1. Decedent's Name (First, Middle, La.	"Shirley	H.	Vinyar		. Date of Death Month May	Day ZØ	Year 2005	3. Time of Death ()
	Examir		4a. Facility Name (If not institution, give Howard County) 5. Social Security Number 6. S	General 1	to spital		n bia	Date of Righ	Ito	ward	
	Funeral Director			□M 2 X) F	78 Yrs.		lours Min.	Date of Birth (Month, Day,	Year) 1926	India	lace (State or Foreign try) ana
	e Maryland a-f show iffice at	ctor	10a. State 10b. County Maryland Howard		c. City, Town or Lo	cation				16	0d. Inside City Limits 1 ☐ Yes 2 No
	with th	Director	10e. Street and Number	#202		10f. Zip Code				of What Coun	try?
920	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "naturel", or liems 23a or 28a-f show event, the Medical Examinar must be notified at	by Funerai	7110 Minstrel Way 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	1f 3 3 3 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 7 No If Yes, Give Year or Dates:		21045 Was Decedent of Hispa f Yes, specify Cuban, M □ Yes ¾ No S	nic Origin? (Specif Mexican, Puerto Ric Specify:	y Yes or No- can, etc.)	14. F	lace - America lack, White, e city: Whit	etc.
21215-0036	within 72 ho ene. than "natur ne Medicel	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occupation kind of work done durin DO NOT use retired)	n ng most of working	1	6b. Kind of	Business/Ind	ustry
d 21	Hygir Hygir ther nt, L		12 17. Father's Name (First, Middle, Last)		Bookk		. Mother's Name (F			L Pharm	nacy
Maryland	should be Ind Mental Ind Mental Insured o	To Be	Robert Clyde Hoove	er		Mo	onta O. H	ess			
Mar	S S S	V B	19a. Informant's Name/Relationship (Mark B. Vinyard/se			ng Address <i>(Street and</i> Swift Curre			-		
Baltimore,	Pages 1 and 2 nent of Health out: if item 27 iny or other tree		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specification)	20c. Location - City or Town, State Odenton, Maryland							
Baltii	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service Lice	Isde Off	G G	el Cremator Name and Address of Ding Home C	f Facility Cremation	Servic	e P.	0. Вох	784
	Pn ysicia n /Medical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Brain Can Cer Due to (or as a consequence of):									Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last	cDue to (or as a co	nsequence of):						
.O. Box	at the death certific by the attending p tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	N/A			Date of delive. Month	ry Day Year
rds, P	quires that n signed b	by	Part II. Other significant conditions of Type II Dial	ontributing to death but no	ot resulting in the u	nderlying cause given in	n Part I.	23e. Did toba	~		e cause of death? ably 4 []Unknown
I Records,		Completed	Type I Dial Essential H Seizure	y pertensio	n			24a. Was an autopsy perform 1 ☐ Yes 2		prior to con death?	osy findings available inpletion of cause of
Vita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:	.,	Othor	. Place of Death (C				
Division of	ling Phys After this uneral dii	Certification; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	28a. Date of Injury (Month, Day Ye	2 ER/Outpatier 28b. Time of Injury	28c. Injury at Work?	4 Nursing Home 28c	5 🗌 Residen d. Describe how)
Divi	ital or Attend rs after death el Director: led in by the f	Certifi	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - building, etc. (S		eet, factory, office	28f	Location (Stre City or Town,		mber or Rural	Route Number,
	To the Hospital or within 24 hours after To the Funerel Dire completely filled in b	ledical	(Check only 2 Medicel Exer	ysicien: To the best of miner: On the basis of exa and manner stated.	y knowledge, deat mination and/or in	vestigation, in my opinio	on, death occurred	at the time, dat	e and plac	e, and due to	the cause(s)
)	con Twith	₩/	29b. Signature and title of certifier	M	m.D.	29c. License nu 5 6	531	290 ′	n ay	128,	2005
	VA	/	30. Name and address of person who Harry Li,	10780 Hi	(Item 23a) (Type,	D 56 Ridge Ru	d, col	umbia	n,	mD.	21044
	Sta Registr	2	31. Date filed (Monty UN: Vaar) 2	005 32 egistrar's	Signature	sell)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician Elena Valuntis 3:50 P /Medical May 2005 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner <u>Genesis Eldercare</u> Severna Park Anne Arundel If Under 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 1 F Yrs Director 4,1924 386-30-6130 80 Lithuanian Dec. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show permit. Pages 1 and 2 should be filled within 72 hours after deeth with the Maryla Deperment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or iteme 23a or 28e-f show any Injury or other traumatic event, the Medical Example and the Lotting and once. 1 ☐ Yes 2 ₽ No Director Maryland Anne Arundel Severna Park 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 582 Richard Way 14. Race - American Indian, Black, White, etc. 21146 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 2 Specify. 3 √Vidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bronius Greicius Katarina Barkauska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jason M. Valuntis (Grandson) 10 East Read Street Baltimore, Maryland 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Femation 3 ☐ Removal from State Bayview Crematory 5/31/05 4 □ Donation 5 □ Other (Specify) Baltimore Maryland ^{22. Name and Address of Facility} McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Funeral Service Licensee Collins 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician years /Medical Due to fer as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 mon Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed eme 24b. Were autopsy findings available prior to completion of eause of death? 24a. Was an page 2 this certificate has 2 No 1 🗌 Yes 1 Yes 35 funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 Tes ٩ 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 atural 5 Pending after death.
I Director: After din by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours after To the Funerat Dire filled To the Hospital 🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registra DHMH 17 Rev 1/2001

State

30

ennit

el 31. Date filed (Month, Day,

s Signature

Name and address of person who completed cause of death (Item 23a); (Type,

I 2005 Registre

				State of Ma						-	•	18358
			For State Registrar			Cei	tificate of	Death			. No.	10000
	Physicia	an	Decedent's Name (First, Middle, La				Washingt	on		ate of Death onth	Day Year	3. Time of Death
E	/Medic		Dorothy		ae ———		Washingt			5 26		8:08am™
	Examin	er	4a. Facility Name (If not institution, give				4b. City, Town, o	r Location of De cimore	eath		4c. County of Death	1
			Good Samaritan H 5. Social Security Number 6.5		a (In vrs. i	last birthday)	If Under 1 Year	If Under 24 F	Hrs. 8 Da	ate of Birth		place (State or Foreign
	Funeral Director			1□M 2X F	86	Yrs.	Months Days		lin. (N	ate of Birth Sonth, Day, Y	1919 Co.	Va.
	TO .		Usual Residence of Decedent									
	arylar show	-	10a. State 10b. County		10c. City	y, Town or Lo						10d. Inside City Limits 1 Yes 2 No
	he M	by Funeral Director	Md. NA 10e. Street and Number			Bal	timore			100	. Citizen of What Cou	
	with the or or	Ö	6401 Loch Raven	Blud Ant	233	<u>!</u>	2123	a		log	USA	muy r
	ns 23	era	11. Marital Status	12. Was Decedent I Armed Forces?			Was Decedent of H		(Specify Y	es or No-	14. Race - Amer	ican Indian,
ယ	or iter	Fur	1 ☐ Never Married 2 ☐ Married	1 □ Yes 2 🗖 N					uerto Rican	, etc.)	Black, White	
Ö	ours ours	d by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🔀 No	Specify:			Specify: B.	lack
<u>2</u>	be filed within 72 hours after death with the Maryland at Hygiene. de Hygiene. de dhar then "neturel", or items 23a or 28a-f show dothar then "neturel", or items 23a or 28a-f show event, the Madical Example of the profiled at	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Deced (Give	dent's Usual Occup kind of work done DO NOT use retire	ation during most of v	working	16	b. Kind of Business/l	ndustry
12	withir ene. then	ошо	Elementary/Secondary (0-12)	College (1-4or 5 NA	i+)		estic-Lau	_			Flder Peo	ole's Home
0 0	filed Hygi othar ent, t	Be C	17. Father's Name (First, Middle, Las			Dome	DCIC Dad		Name (Firs		iden Surname)	ore b home
<u>a</u>	lic ev	To B	Willie			Lewis		Mar	ie		McCa:	rgo
Maryland 21215-0036	and A		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street	and Number or	Rural Rou	te Number, C	City or Town, State, Z	p Code)
∑ 	and and n 27 n 27 nar tr	3	Elsie Bert-Daug	nter	1	_	3 Winsto				ore, Md.	21239
Ore	ges 1 t of H ff ite or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	☐Removal from State			sition (Name of natory or other pla		Date		c. Location - City or 1	
Baltimore,	t. Par rtmen rtent: nlury		1 Burial 2 Cremation 3 C		C		ville Vet		-2-05		Crownsvil.	
Ba	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mertal Hygiene. Department of Health and Mertal Hygiene. The Importent if item 27 is marked other then "neturel", or flems 23a or 28a-f show any injury or other treumatic event, the Medical Examinar master molified at once.		21. Signature of Funeral Service Lice	1,200	سف		Name and Address		1.		more, Md. North Ave	21202
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	polications that caused one cause on each fir	the death	n. Do not ent	er the mode of dyir	ng, such as card	diac or resp	iratory arres	t,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. My0	car	dial	Info	-ction				Oriset and Death
	/Medical Examiner		resulting in death)	Due to (or s	a consequ	uence of):	Infor					
		-ia	Sequentially list conditions,	b. Due to (or as	a conseq	ence of):	tery D	Seese				
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
o	ate be exacuted hysician and he burial-transit	Еха	resulting in death) Last	Due to (or as	a consequ	uence of):						
3760,	ate be hysici he bu	lical	•	d								
x 68	ertific ling pl	Mec	IF FEMALE:	00-16	_4							
Bo	ath cattend	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3	Ectopic pregnancy Other (specify)	У			23d. Date of deliver Month	rery Day Year
P.O. Box	that the death certifical ed by the attending phi detached for use as th	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	tillia or di	eau J						
	The law requires that the death certifica ite has baan signed by the attending phage 2 should be detached for use as the	by Physician/Med	Part II. Other significant conditions	contributing to death b	ut not resi	ulting in the u	nderlying cause giv	en in Part I.	2	3e. Did toba	cco use contribute to	the cause of death?
Vital Records,	w requires that baan signed b should be deta	ed p	Gastric	Carcinon	2				_	1 🗆 Yes	20 No 3 □ Pro	bably 4 Unknown
000	ie law re has bas ge 2 sho	Completed							2	4a. Was an autopsy	24b. Were aut	opsy findings available
m m	The ate ha	Com							1	performe □ Yes 😅	d? death?	·
/ita	cian: ertific ector,	Be	25. Was case referred to medical examiner?	11.			100	26. Place of I	Death (Che	ck only one)		
	Physi this o	T _o	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie		ER/Outpatier 28b. Time of	IL 3L DOA				ce 6 □Other (Spec	ify)
ng	ding the After funer	tion	1 Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	Year)	Injury	Wo	rk? Yes 2 □ No	200. L	rescribe now	injury occurred	
Division of	Attending Physician: ir death. ector: After this certifice by the funeral director, i	fical	3 ☐ Suicide 6 ☐ Could not I	28e. Place of Inju			eet, factory, office		28f. Lo	ocation (Stre	et and Number or Ru	ral Route Number,
<u>S</u>	el or A s after il Direct	Certification:	4 ☐ Homicide	building, etc	c. (Specify	y)			<i>C</i>	ity or Town, .	State)	
	To the Hospitel or Attending Physician: The I within 24 Hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical (29a. Certifier 1 Certifying P (Check only one)	hysician: To the best of miner: On the basis of and manner sta	examina	wledge, death tion and/or in	n occurred at the til vestigation, in my o	me, date and pla opinion, death o	ace, and di ccurred at	ue to the cau the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	296. Signature and title of certifier				29c. Licens	se number		290	l. Date signed (Month	, Day, Year)
	1 /	/	1 Dan Be	halit M	D		800	57237		1	1cy 27,20	05
1	11		30. Name and address of person who	completed cause of d	eath (Item	23a) (Type,	Print)	1 has -	MIN	2125	7	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signa	ture	St., Ba	TIONIT			•	
	Registr		JUN	0 1 2005	Flores.	u B	Cools	9				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 🥬 🦳 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2005 **Physician** Evelyn B. Wagner May 6:15 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson Baltimore Gilchrist Center 8. Date of Birth (Month, Day, Year)
Aug. 17, 1914 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 XF 90 212-09-0560 Director Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location. 10d. Inside City Limits or 28e-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 12 Moray Court 21236 U.S.A. or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? Black, White, etc. ☐Yes 2XNo Yes, Give 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates: 'naturel', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiens important; if flem 27 is marked other than "any in]ury or other traumatic content than " Elementary/Secondary (0-12) College (1-4or 5+) Controller 8th Grade Entertainment 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Harry A. Wagner Mary Rosenberger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Charles Wagner (brother) 939 Beaverbank Circle, Towson, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory ' 4 ☐ Donation 5 ☐ Other (Specify) 6/2/2005 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebrorascular disecse **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): burial-1 attending physician Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Dav 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 1 Tes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy mea? 2₩ No 1 ☐ Yes 2 ☐ No 1 Yes Hospitel or Attending Physicien: 24 hours after death. Funerel Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 ☐ Yes 2 No 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier To the within 2 29c. License number 29d. Date signed (Month, Dav. Year) 29b Signature and title of certifier D 58302 MAY 27 2005 30. Native and address of person who completed cause of death (Item 23a) (Type, Print) Charles of Microwitz wo 21204 n AAron Charles 6601 m

DHMH 17 Rev 1/200

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 For Stata	State of Maryland /	Department of He Certificate of D			2001	5 10000						
			Registrar 1. Decedent's Name (First, Middle, La	ist)	Certificate of D		Reg. No. 1		3. Time of Death						
	Physici /Medi		RAYMOND (HRISTOPHER	WALDRON	0		B ZOO	NO A M						
	Examir		4a. Facility Name (If not institution, give	re street and number)	4b. City, Town, or L		4	c. County of De	eath						
			5. Social Security Number 6.5	Sex 7. Age (In yrs. last b		NORE If Under 24 Hrs. B	Data of Righ	0.5	list-land (State of Francisco						
	Funeral Director			12M 2DF 41	Yrs. Months Days	Hours Min.	Date of Birth (Month, Day, Yea	963 N	Sirthplace (State or Foreign Country)						
	D		Usual Residence of Decedent				01-	765							
	arylar show	7	10a. State 10b. County		wn or Location				10d. Inside City Limits 1 ☐ Yes 2 ☑ No						
	the M	ecto	10e. Street and Number	IMORE [10f. Zip Code		10g (Citizen of What							
	3a or	i Di	6531 RICE		2107	5		115	\(\rightarrow\)						
	death	nera	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Specif	y Yes or No-	14. Race - Ar Black, Wi	merican Indian,						
36	s after	by Funeral Director	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tes 2 No		Specity:			OHITE						
21215-0036	72 hours after death with the Maryland Insturel', or Itams 23a or 28a-1 show insal Examitter must be motified at	ed b	15. Decedent's E	Year or Dates:	ia. Decedent's Usual Occupati	on	16b.	Kind of Busines							
215	within 72 ena. then "na	plet	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give kind of work done dur life. DO NOT use retired)	ring most of working									
	ygient ygient rer the	Completed	12	(CARMENT	ER			RUCTION						
and	be fill ad oth	Be	17. Father's Name (First, Middle, Las.		1	8. Mother's Name (F	irst, Middle, Maide	n Sumame)	VE						
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiena. Ifem 27 is marked other then "naturel", or Itams 23a or 28a-1 show other traumatic event, I're Mydical Experiment the multiled at	은	19a. Informant's Name/Relationship	Type. Print)	9b. Mailing Address (Street and	d Number or Rural R	oute Number. City	or Town State	Zin Code)						
	1 and 2 s Health ar tem 27 is			YON FATHER 2	401 E. N	CRIHERA	S Prewi	1	, _, _,						
ore,	of Her fitem	H	20a. Method of Disposition	romet	of Disposition (Name of tery, crematory or other place)	Date		Location - City							
Baltimore,	mit. Pages partment of ortant: If it injury or o		'4 □Donation 5 □Other (Speci		ESEPH CHURCH	6.1.20	Fu	LLERIC	CM,CA						
Ball	permit. Pages 1 and Department of Health Important: If item 27 eny injury or other tr once.	21. Signature of Funeral Service Licensee MC/220 22. Name and Address of Facility PLACEFUL ACTERNATIVES 23. Signature of Funeral Service Licensee ACTERNATIVES 23. Name and Address of Facility PLACEFUL ACTERNATIVES MC/220 23. Name and Address of Facility PLACEFUL ACTERNATIVES MC/220 23. Name and Address of Facility PLACEFUL ACTERNATIVES MC/220 23. Name and Address of Facility PLACEFUL ACTERNATIVES													
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximately a cause of the death of the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, linterval.												
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Lung Cance					Years						
	/Medical Examiner		Todain, g in docum,	Due to (or as a consequence	e of):				13.50						
1/		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence	e of):										
V	tificate be exacuted g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C											
68760,	be extician a	ai Ex	resulting in death) Last	Due to (or as a consequence	e of):										
687	ficate physics the	edicai		d											
Вох	eath cartifi attending for usa as	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	th 3 Ectopic pregnancy			23d. Date of d	lelivery						
	the the	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of death 9☐Unknown	5 Other (specify)			Month	Day Year						
P.O.	that the	/ Ph	Part II. Other significant conditions	contributing to death but not resulting	in the underlying cause given	in Part I.	23e. Did tobacco	use contribute	to the cause of death?						
of Vital Records,	w raquires that bean signed k should be det	d by					1XYes	2 □ No 3 □	Probably 4 Unknown						
000	aw rac s bear 2 shou	piete	11				24a. Was an	24b. Were	autopsy findings available completion of cause of						
R	The late happage	Completed		· · · · · · · · · · · · · · · · · · ·			autopsy performed? 1 ☐ Yes 2 ☐	death?	es 2 No						
/ita	cian: ertific ector,	Be	25. Was case referred to medical examiner?	kli		26. Place of Death (C	heck only one)								
of \	Physician: r this certificatal director,	. To	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ ER/C		4 - Indianing Home	5 Residence Describe how ini	6 Other (Sp	pecify) (1050, ce						
on	Attending P r death. sctor: After the by the funera	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury Work?	s 2 □ No	. 50301150 (1011 111)	ary coods ou							
Division	r Atter er dea rector by the	Certification:	3 Suicide 6 Could not to		farm, street, factory, office	28f	Location (Street a City or Town, Sta	and Number or i	Rural Route Number,						
	itel or A														
	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Cartifying P (Check only one) 2 Medical Exa	hysician: To the best of my knowled minar: On the basis of examination a and manner stated.	ge, death occurred at the time, and/or investigation, in my opin	date and place, and ion, death occurred	due to the cause(at the time, date a	s) and manner and place, and di	as stated. ue to the cause(s)						
	To the within To the comp	Me	29b. Signature and title of certifier	2 . 1	29c. License r		29d. D	ate signed (Mo	nth, Day, Year)						
)			I faron I fla		1006	1199	M	17, 2	8.2005						
	10		30. Name and address of person who			Tour	- MI)	21201	4						
	. Sta		31. Date filed (Month, Day, Year)	32. Segistrar's Signature		7 330			(
	Registi	ar	2214 0 1 7	M . COU.	Locall 1										

Waldron, Raymond, 5/28/05 250 Am

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend Items: 8,9 per Infor.G-844 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2005 MAY **Physician** FRED D. WRIGHT 29 5:15 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDRICK VILLA NURSING HOME CATONSVILLE BALTIMORE If Under 24 Hrs. If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10/28/1920 1**∑**M 2□F Months Days Hours Min. 251-20-4706 84 NORTH CAROLINA Yrs Director 10/20/1920 South Carolina Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d Inside City Limits r 28e-f show 10a State 10b County MD N/A BALTIMORE CITY XXYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with Fxaminer must be 336 N. HILTON STREET 21229 USA death Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in 14.5. Anned Forces? 1 X Yes 2 □ No NAVY If Yes, Give 14. Bace - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes XX No Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced "neturel" 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) PARKING ATTENDANT 4TH GRADE ALLRIGHT PARKING CO. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental (UNKNOWN) THOMAS ROSA ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health 336 N. HILTON STREET, BALTIMORE, MD 21229 LENA WRIGHT / WIFE item 2 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Department of P Importent: If its eny injury or of once. MD WESTERANS CEMETERY GARRISON FOREST XXBurial 2 Cremation 3 Removal from State 06/07/05 OWINGS MILLS, MD ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD 21207 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Litter the ock, or leart Approximate Interval Between Onset and Death Immediat ause (Final disea or condition Physician men resulting in death) /Medical Due to (or as a consequence of) Examiner Lucasi Winson Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) sician ar burial-tı Box 68760 Physician/Medicai attending phys the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No the 9 Unknown à signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 3 No Division of Vital the Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3□ DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide lilled 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certify

17

State Registrar 3451

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMBANDA

KARAN

30

WIKEWS ANE BALTIMOR

2005

			1 100	State of Ma				of Health		•	iene	egibic.	
		-	For State Registrar	State of Me	ai y tai ia			of Death			g. No.	005	18362
			Registrar Decedent's Name (First, Midd.	fle, Last)			imouto	0, 000.		2. Date of Deat			3. Time of Death
	Physicia	an								Month May	Day 25.	Year 2005	5:00 P ^M
	/Medic Examin	_	Edna Ma 4a. Facility Name (If not institutio		е		4b. City, To	wn, or Location	n of Death	11ay		ounty of Deat	
	Examin	E	2914 Bristol C	_				Pasade	na		Δ	inne Ar	undol
	Funeral		5. Social Security Number	6. Sex 7. Age	e (in yrs. la	st birthday)	If Under 1 Months E	Year If Unde	r 24 Hrs. 8	B. Date of Birth (Month, Day,			nplace (State or Foreign untry)
н	Director		214-22-5322	1 □ M 2 🗹 🗲	78	Yrs.	MOUTH	Jays Hours	191111.	Aug. 1			yĺand
7	D >		Usual Residence of Decedent 10a, State 10b, County	v	10c City	Town or Lo	cation						10d. Inside City Limits
1	sho	5											1 ☐ Yes 2 ☑ No
3	28a-f	Director	Maryland Ann	ne Arundel	Pa	sadena	10f. Zip Co	ode		1	Oa. Citize	n of What Co	untry?
	tiled within 72 hours after death with the Maryland Hygiene, sharthen "naturel", or Items 23a or 28a-f show ent, the Medical Evaruher must be notified at			Ch 1 . C t			101.2.0		0		- 9		
4	ns 23	Funerai	2914 Bristol C	12. Was Decedent	Ever in U.S	. 13.	Was Deceder	2112 nt of Hispanic C Cuban, Mexic		ify Yes or No-	14	. Race - Ame	rican Indian,
	Ther r	돌	1 ☐ Never Married 2 ☐ Mar	Armed Forces? trried 1 ☐ Yes 2 ⊡1	40	1				ican, etc.)		Black, White	e, etc.
ဗ္ဗ	ers a	þ	3 ⊠Widowed 4 □ Divorce	od If Yes, Give Year or Dates:			1□Yes 2⊡	No Specif	y:		S	pecify: Wh	ite
ည်	natur	Completed	15. Deceder	ent's Education est grade completed)		(Give	dent's Usual (done durina ma	ost of working	9	16b. Kind	of Business/	Industry
2	in in in in in in in in in in in in in i	현	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life.	DO NOT use	retired)					. 1 11
2	ygier ygier her th		12	N/A		_Swite	chboard	1 Opera		(First. Middle. I			Baseball
ב י	be til hd ott	Be	17. Father's Name (First, Middle,	, Last)				18. MOL	nei s ivanie (riisi, ivilaale, i	naiueri Si	,	
Maryland 21215-0036	narke	유	James 19a, Informant's Name/Relation	achin (Time Brint)	Ca	ldwel		Lo Street and Num	uise	Poute Number	City or T		stra
Na Na	12 St hand 7 Ian traun						-				-		.p 5040)
O	1 and Healt em 2 ther		Faye L. Slater 20a. Method of Disposition	(Daughter)	20b. Pla	2914 ace of Dispo	oriston esition (Name	ol Chan of er place)	nel Co Da	urt las	20c. Loca	tion - City or	21122 Town, State
و	ages ntof :: If it		1 Burial 2 □ Cremation										M1 1
Baltimore,	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. I be importment of Health and Mental Hygiene. I have them 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evantical ritual be notified at once.	-	* 4 □Donation 5 □ Other (3		MO		Mem.		5/28/				Maryland
Ba	Depa Depa Impo any ir		be by 7	F Cali		Mo	Cully-	Address of Fac -Polynia intain	ak Fun	eral Ho	ome,	P.A.	21122
			23a. Part 1 Inter the disease, of shock, or heart failure. Lis	or complications that causes	the death.	Do not ent	er the mode of	of dying, such a	s cardiac or	respiratory arr	est,	rytano	Approximate
Н.	No		Immediate Cause (Final										Interval Between Onset and Death
ш	hysician /Medical		disease or condition resulting in death)	aDue to or as	a conseque	ence of):	2170	Disea	r)				
E	Examiner			Coron	ary	Arl	cry	Disea	se				
		Je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a cortingue	ence of):	4						
f:	icuted nd transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	o. Diah			thi tous	<u> </u>					
760,	le be executed ysician and le burial-transit	Ë	resulting in death) cast	Due to (or as	a conseque	ence of):							
876	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	dicai		d									
× 68	ding p	/Me	IF FEMALE:	23c. If yes, outcome	of pregnan	ncv					234	d. Date of del	iven
Вох	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3	Ectopic preg				200	Month	Day Year
P.O.	the d	Physician/Med	1 □ Yes 2,☑No 9 □ Unknown	9☐ Unknown				,,					
م	The law requires that the death certilical tee has been signed by the attending phoage 2 should be detached for use as the	by Pł	Part II. Other significant condit	tions contributing to death b	out not resul	lting in the u	nderlying cau	se given in Par	t I.	23e. Did tol	oacco use	contribute to	the cause of death?
rds	v requires been sign should be	d be								1 🗆 Y	s 2 🗆	No 3□Pr	obably 4.⊟Unknown
00	aw requ s been 2 shouk	Completed								24a. Was a		24b. Were au	topsy findings available completion of cause of
æ	The lay te has age 2	E								perfor	ned? No	death?	_ 4
ital	ian: rtifica stor. p	Bec	25. Was case referred to medic examiner?	al						(Check only on	(a)		
>	nyaic nis ce I direc	Tof	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 🗆 E	R/Outpatier	nt 3 DOA			e 5.□Reside			cify)
0 0	ng Pl		27. Manner of Death 1. □Natural 5 □ Pend	28a. Date of Inju	y Year)	28b. Time o Injury		. Injury at Work?		8d. Describe h	ow injury o	occurred	
sio	tendi eath. ior: A the fu	cati	2 Accident inves 3 Suicide 6 Could	stigation			М	1 Tes 2		9f Leastion (C	root and i	Number or P	ıral Route Number,
Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	4 Homicide deter	d not be rmined 28e. Place of In building, et	tc. (Specify)	ne, rarm, st	reet, ractory, o	Office	20	City or Town	n, State)	Valliber of the	mar riodio redirioor,
	pital ours a eral I		29a, Certifier 1 Certify	ring Physician: To the best	of my know	viedae, deat	h occurred at	the time, date	and place, ar	nd due to the c	ause(s) ar	nd manner as	stated.
	9 Hos 24 h Fun etely	Medical	(Check only 2 Medica one)	al Examiner: On the basis of and manner st	of examinati	on and/or in	vestigation, ir	n my opinion, d	eath occurre	d at the time, d	ate and p	lace, and due	to the cause(s)
	ro th vithin ro th	Me	29b. Signature and title of certifi	ier			29c. l	License numbe	4 7	2	9d. Date	signed (Monti	h, Day, Year)
	/		· Churto a	man_	_		D	00524	190		Ma	926,	2005
	1		30. Name and address of person	on who completed cause of	death (Item	23а) (Туре,	Print)	0 10 1	»2_ i	0 - 14-	25.00	nan	212 25
_	り		Anita Khano	celled will	3001	15.	Han	S 3200	r · 1	2411M	vive	, , , ,	xize
		ate	29b. Signature and title of certification of the Country of the Co	32. Registi	rar's Signat	ure	A SOLE ASIA						
	Regist	rar	30:	2 0 2			16.						

Please Type or Print in Black Indelible Ink	. Ensure All Copies Are Legible
---	---------------------------------

			For State Registrar		laryland		tment of ificate o	Health and f Death		Reg. No.		18363	
	Physici /Medi	an	Decedent's Name (First, Middle, I JOY		NN	WUN	DER		2. Date of De Month	Day	2005	3. Time of Death	
	Examir	er	4a. Facility Name (If not institution, s	ive street and number	lat c	ante	4b. City, Town	or Location of De	ath 0		County of Death	ico	
	Funeral Director		5. Social Security Number 6 216-52-9904 Usual Residence of Decedent	Sex 7. A	ge (In yrs. Ia 54	Yrs.	If Under 1 Yea Months Day			ay, Year)	Cour		
	Maryland f show	tor	10a. State 10b. County	erset	10c. City,	Town or Loca		estover			1	0d. Inside City Limits 1 ☐ Yes 2√ No	
	with the sa or 28e Le noti	Dire	10e. Street and Number 5760 Coventry Pa				10f. Zip Code			10g. Citi	zen of What Cour	ntry?	
036	72 hours after death with the Maryland neturel; or Items 23s or 28e-f show Jical Ess piret must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces	? ?No		as Decedent of Yes, specify Co	f Hispanic Origin? uban, Mexican, Pu	(Specify Yes or Ne erto Rican, etc.)	0-	14. Race - Americ Black, White, Specify: Wh:	etc.	
21215-0036	within 72 hours ene. than "neturel",	Completed by	15. Decedent's (Specify only highest : Elementary/Secondary (0-12)	Education grade completed) College (1-4or	5+)	16a. Decede (Give ki life. Do	nt's Usual Occ ind of work dor O NOT use ret	supation se during most of w red)	vorking	16b. Ki	nd of Business/In	dustry	
	be filed ital Hygi ed other event, I	Be	12 17. Father's Name (First, Middle, La	st)			Homema	18. Mother's N	lame (First, Middle	, Maiden	Own Home Sumame)	2	
Maryland	s 1 and 2 should be f Health and Mental item 27 is marked o other treumatic eve	스	Elroy Williams 19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing	Address (Stre	et and Number or	y Boggs Rural Route Numb	er, City o	r Town, State, Zip	code)	
	00		John F. Wunder 20a. Method of Disposition 1又Burial 2□Cremation 3	☐Removal from State	e Ce	ace of Disposi metery, crema	tion (Name of atory or other p		Date		over, Mocation - City or To		
Baltimore,	artr artr injudication		*4 □Donation 5 □Other (Spe 21. Signature of Funeral Service Lie		Reho		Name and Add	n Cemetery dress of Facility naw & Son			cover, M	aryland	
	Physician		23a. Part1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final	ly one cause on each	ed the death. line.		the mode of c	. Main St ying, such as card	reet - C iac or respiratory a	rief:	ield, Md	21217 Approximate Interval Between Onset and Death	
	/Medical Examiner		disease or condition resulting in death)	Due to (or a	s a consequi	ence of):	rear	t Conc				19 42413	•
/	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С.	s a conseque								
8760,	icate be ex physician s the burial			d	s a consequi	ence or).					-		_
P.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and oate 2 should be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 🗌 Fetal	death 3□E	Ectopic pregna Other (specify)				23d. Date of delive Month	ery Day Year	
rds, P.	quires that n signed b uld be deta	þ	Part II. Dther significant condition	s contributing to death	but not resul	lting in the und	derlying cause	given in Part I.				he cause of death?	
		Completed							24a. Was		24b. Were auto prior to co death? 1 \(\text{Yes}	opsy findings available impletion of cause of	
Vital	ician: certific rector,	To Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑No	Hospital:	tient 2□F	ER/Outpatient	3□ DOA	7th or	eath (Check only)		6 ∏Other (Specia	fv)	
	Attending Phys r death. ector: After this by the funeral did		27. Manner of Death 1 Autural 5 Pending 2 Accident investiga	28a. Date of In (Month, D	jury	28b. Time of Injury	28c. lr	ijury at Vork?	28d. Describe		-	<i>y</i> /	
=	in Sir fe	Certification:	3 Suicide 6 Could no determin	200. Place of I	njury - At hor etc. (Specify,	me, farm, stre	et, factory, offi	De .	28f. Location City or To		d Number or Rura)	al Route Number,	
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical		Physician: To the best aminer: On the basis and manner	of examinati								
	To the To the comp	Ž	29b. Signature and title of certifier		.0.			30690		m.	te signed (Month,		
•			30. Name and address person w	no completed cause of	death (Item	23a) (Type, P	rint)	Greatt	sy 5	150	600-	mD.2180	i
	St	ate rar	Ot Date Stad (Month Day Vons)	1 2005 ^{32. Regis}	strar's Signat	urds. A	perte					- · 6/ 60	

State of Maryland / Department of Health and Mental Hygiene 8364 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** MAY 28 6:15 P M **7ELKOWITZ** BESSIE 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE BALTIMORE MILFORD MANOR NURSING HOME 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 08/15/1914 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F md 216-03-3266 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County *oue direct court by notified at 1 ☐ Yes 2 ☑ No BALTIMORE BALTIMORE Director 28a-1 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21208 USA 4204 OLD MILFORD MILL ROAD 238 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. or Items Black, White, etc. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ other traumatic event, the Medical Exam 3 Widowed 4 Divorced WHITE "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **CLERK** BAKERY 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mental Pages 1 and 2 should be item 27 is marked ZELKOWITZ CELIA SAVAGE **ISADORE** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ROBERT TUCKER / NEPHEW 3708 CLARINTH ROAD - BALTIMORE, MD 21215 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages:
Department of the important: If its any injury or ot once. 1 ABurial 2 Cremation 3 Removal from State SHAAREI TFILOH CEM. 05/30/2005 WOODLAWN, MD * 4 Donationy 5 Other (Specify) 22. Name and Address of Facility rant Funeral Service Lip SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroscierotic Cardiovascular Disease Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any, leaving unimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical phys ası IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 9 Unknown The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 Honknown Hypertension 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Thrombocytopenia 24a. Was an autopsy page performed? 2 No 1 🗌 Yes 2 🗌 No 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Hatural 5 Pending Injury within 24 hours arrest To the Funeral Director: Att 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. l bed 29c. License number 29d. Date signed (Month, Day, Year) Karen & Balret, M.D. 00058676 may 29, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Karen L. Babitt, 25 Main Street Suite 200. Reisterstown, MD 21136 M , 1). 32. Register's Signature 31. Date filed (Month, Day, Year) JUN 0 1 2005 > Registrar

			For State Registrar	State of M		/ Depa	artment of	Health	and M	lental Hy	-	05	18365
	Physici	an	1. Decedent's Name (First, Middle, Louis Franklir			-				2. Date of De Month May		Year 2005	3. Time of Death 2:15 p M
	/Medic Examin		4a. Facility Name (If not institution,				4b. City, Town	n, or Location	n of Death	May	4c. Coun	ty of Death	
	Funeral		269 Pertch Roa 5. Social Security Number 6		je (In yrs. last	birthday)	If Under 1 Ye	ar If Unde	na Pa			ne Ar	undel place (State or Foreign
	Director		467-66-5736 Usual Residence of Decedent	1 ⊠ M 2□ F	58	Yrs.	Months Day	ys Hours	Min.	8. Date of Bir (Month, Da Jul. 3	0, 1946	Cour	TX
	uryland show	_	10a. State 10b. County	Arundel	10c. City, T	own or Lo		rna Pa	nele			1	10d. Inside City Limits
	the Ma 28a-1	recto	10e. Street and Number	AL UTIGET			10f. Zip Cod				10g. Citizen of	f What Cour	1 ☐ Yes 2 🛣 No
	23a or	rai Di	269 Pertch Road	l				21146				JSA	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 XYes 2 If Yes, Give Year or Dates:	No		Vas Decedent of Yes, specify C			ecify Yes or No Rican, etc.)	- 14. Ra BI Spec	ace - Americ ack, White, ify:	
21215-0036	within 72 ho ene. than "natui ne Medical	ompleted	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12			(Give life. l	lent's Usual Oc kind of work do DO NOT use rei	ne during mo tired)		ing	16b. Kind of Feder		overnment
nd 2	oe filed tal Hygi d other event, I	To Be Co	17. Father's Name (First, Middle, La	ist)				18. Mot	her's Name	(First, Middle,	Maiden Suma		
Maryland	should Ind Mening Market	၉	Leonard Adams 19a. Informant's Name/Relationshi	o (Type, Print)		19b. Mailin	g Address (Stre			Thompso:		n, State, Zip	Code)
	and 2 ; ealth ar m 27 ia ner trau		Beverly A. Adam	ns/Wife	les si	44.00	Pertch				•	21146	
Baltimore,	. Pages 1 Iment of H Iant: if ite jury or ott		20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 1 ☐ Donation 5 ☐ Other (Spe			co Cr	sition (Name of natory or other) ematory		May 20	0ate 17, 005	Baltin		
Bai	Departimonal Depar		21. Signature of Funeral Service Li	Consider Du		B 4	. Name and Ad arranco 95 Cov	dress of Fac & SOT Ritch	ns, P.	A. Sev	erna Pa	rk Fu	neral Home D 21146
2	Pnysician /Medical		23a. Part1. Enter the disease, or chock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	aa	ne.	o not ent		dying, such a	is cardiac c				Approximate Interval Between Onset and Death NS 9MOS
	Examiner			Due to (or as	a consequen	ce of):							
	hed nsit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury		a consequen	ce of):							
,092	ate be executed hysicien and the burial-transit	icai Exar	that initiated events resulting in death) Last	c. Due to (or as	a consequen	ce of):							
Box 68	death certifica e attending phi ed for use as th		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				-:224		23d. D	ate of delive	эгу
o.	that the death certifica ed by the attending ph detached for use as th	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □Live birth 4 □ Pregnant a 9 □ Unknown			Ectopic pregna Other (specify)				N	lonth	Day Year
ords, P	The law requires that the ste has been signed by th bage 2 should be detache		Part II. Other significant condition	s contributing to death b	out not resultin	ng in the ur	nderlying cause	given in Pari	t I.		obacco use col res 2 No	ntribute to th 3 □ Prob	ne cause of death?
Vital Record		Completed								24a. Was autop perfo 1 🗆 Yes	rmed?	. Were auto prior to co death? 1 \(\text{Yes} \)	psy findings available mpletion of cause of
Z Z	Phyaician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2□ER	/Outpatien	t 3□ DOA	Other		n <i>(Check only o</i>		ther (Specif	y)
on of			27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga	28a. Date of Inju (Month, Da	iry 28 ly Year)	b. Time of Injury	V	njury at Work? Yes 2[28d. Describe I	now inju ry occu	ırred	
Division	or Atten fter deat lirector: n by the	Certification;	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of In	jury - At home tc. (Specify)	, farm, str				28f. Location (S City or Tov		ber or Rura	Il Route Number,
	To the Hospital or within 24 hours after To the Funeral Dirticompletely filled in In	edical	29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the best caminer: On the basis of and manner st	of examination	dge, death and/or inv	n occurred at the restigation, in m	e time, date a ny opinion, de	and place, a	and due to the ed at the time,	cause(s) and n date and place	nanner as si , and due to	tated. o the cause(s)
į	To t within To tl	W	29b. Signature and title of certifier	mille	0		D	1983	8		29d. Date sign	1201	05
			30. Name and address of person w	Selouicu	death (Item 23		Print) DO B	esta	ate	Ra. V	Funa	polis	ud.
	Sta Registr		31. Date filed (Month, Day, Year)	7 2005 32. Revistr	rar's Signature	k .	had -	0					
DI	MH 17 Pay 1/2					-							

			For State	State of	Maryla	•	artment of F		nd Mental Hy	20	105	10066
			Registrar 1. Decedent's Name (First, Middle, La	ıst)		061	tillcate of	Dealii	2. Date of D		UU	3. Time of Death
н	Physicia		HILA WALTER	ANDERS	ON. J	R.			Month MAY 1	9, 200	Year	4:30 ₽ ^M
	/Medio		4a. Facility Name (If not institution, gi				4b. City, Town, o	r Location of			nty of Death	
			202 ACADIA ROA	AD			WALDO	RF			HARLE	S
	Funeral			Sex 1[X]M 2□ F		. last birthday)	ff Under 1 Year Months Days	If Under 2 Hours	4 Hrs. 8. Date of Bi (Month, D NOV • 9	rth ay, Year)	9. Birthi Cou	place (State or Foreign ntry)
	Director		573-10-6045	- Дин 201	86	Yrs.			NOV.9	,1918	CAL	IFORNIA
	land		10a. State 10b. County		10 c . C	ity, Town or Lo	cation					10d. Inside City Limits
	Mary	ţ	ARYLAND CHARLI	S	W	ALDOR	£					-1 ☐ Yes 2 X Mo
	or 288	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	ntry?
	th wit		202 ACADIA ROAI)			2060				S.A.	
	r dea	Funeral	11. Marital Status	12. Was Dece Armed For	ces?	U.S. 13.	Was Decedent of H If Yes, specify Cubi	lispanic Orig an, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	0- 14. F	Race - Ameri Black, White,	
36	hours after death with the Maryland turel; or Items 23a or 28a-f show of Eraciliner must be notified at	by Fi	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	ty Tyes if Yes, Give	2□No e ites:WWI	- T	1 ☐ Yes 2 ☒ No	Specify:		Spe	city: WH	ITE
윽	turel		15. Decedent's 8		wes. WWI	16a. Dece	dent's Usuaf Occup			16b. Kind of	f Business/Ir	ndustry
212	within 72 ene. than "nat	Completed	(Specify only highest gas Elementary/Secondary (0-12)		-4or 5+)	(Give	kind of work done DO NOT use retire	during most d)	of working			
21	od with	Som	12	<u>5</u> +		INDU	STRIAL				O-JET	
nd	be filed Ital Hygir of other event, L	Be	17. Father's Name (First, Middle, Las						's Name (First, Middle			
Maryland 21215-0036	2 should be and Mental Is marked eumatic ev	P L	HILA WALTER Al		, SR.		na Addraga /Stract		E KATHRY or Rural Route Numb			- Codol
Mai	d2st thanc 7 Is n treun		BETTY J. ANDEI		FE				, WALDOR	•	206	•
	s 1 and 2 should be filed within 72 hours after death with the Marylan if health and Mental Hygiene if the state of 21s marked other than "naturel", or items 23a or 28a-f show other traumatic event, Ite Medicul Eraciliar must be notified at		20a. Method of Disposition	COOK WI		Place of Dispo	sition (Name of	1	Date		on - City or T	
JOE I	0 0		1 Burial 2 Cremation 3 Condition 4 Donation 5 Other (Spec			-	matory`or other pla TANICDEI		Y 5-21-0	F ALES	Y N NI D D	TA VA
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Lice		M0047	9 3	Name and Addre	ss of Facility	,			IN/ VA
ä			Minhand	X-					RAL SERV		? A	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that ca one cause on ea	aused the dea	ath. Do not en				arrest,		Approximate Interval Between
	Physician		fmmediate Cause (Finaf disease or condition	Pa Po	unki	ngen	10	113	easi			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):						0
		ē	Sequentially list conditions,	b. Due to (or as a conse	equence of):						
	uted d ansit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
o,	be executed sician and burial-transit	Еха	resulting in death) Last	Due to (or as a conse	equence of):						
8760,	sate be executed physician and the burial-transit	dicai		d								
9	ertific ling p	Med	IF FEMALE:	GOO If was out						Till		
Вох	eath certific attending p I for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		irth 2 ☐ Fe ant at time of	tal death 3[Ectopic pregnancy Other (specify)	у			Date of deliv Month	ery Day Year
o.	at the de by the a tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unkno		douin 5						
٦,	The law requires that the death certific ate has been signed by the attending ragge 2 should be detached for use as	by Pt	Part II. Other significant conditions	contributing to de	ath but not re	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco use c	ontribute to	the cause of death?
Records,	en sig	edi							1	Yes 2 No) 3 ☐ Pro	bably 4 Unknown
900	as been 2 shoul	Completed			<u> </u>				24a. Wa	s an 24	b. Were auto	opsy findings available ompletion of cause of
E.		Con							per 1 Tyes	ormed? 2 No	death?	2□ No
Vital	icien: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Ott	26. Place	of Death (Check only	one)		
of	Phys this al dii	-T	1 Yes 2 No	28a. Date o		☐ ER/Outpatie	nt 3 DOA	4 📙 Nur	sing Home 5 Res	how injury oc		(fy)
		tion	1 Natural 5 Pending 2 Accident investigati	(Mont	h, Day Year)	Injury	Wo	rk?]Yes 2□N		,.,.,		
Division	or Attendiater death. Director: A	ifica	3 Suicide 6 Could not determine	be 28e. Place	of Injury - At	home, farm, st	reet, factory, office		28f. Location	(Street and Nu	mber or Rur	al Route Number,
Ö	s after al Direct ed in by	Certification:	4 - Homeige	Danair	ng, etc. (Spec	y)			Only of			4
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical			asis of examin				d place, and due to the h occurred at the time			
	To the within To the	Me	29b. Signature and title of certifier	4 17	0.41	M	29c. Licens	se number		29d. Date sig	ned (Month,	Day, Year)
			18 xy 20	5.9	ein	//-	102	55	17	5	120	103
			30. Name and address of person wh	completed caus	e of death (Ite			or t	tolo in/A	dorfin	11	N D'
	, Sta	nte.	Balleet Seth 31. Date filed (Month, Day Year)	32.	gistrar's Sign	nature	prode	de -	014 VVA	20177	د د د	000
	Regist		JUN 0 1	2005	gistrar's Sign	J. A	book					

			1 - State of Maryland / Do	epartment of F			iene	05	18	367
			Decedent's Name (First, Middle, Last)			2. Date of Deat	h		3. Time of	f Death
я	Physici		Robert R. Belt, Sr.			Month May 13	, 2005	Year	7:25	РM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	or Location of Death	1147 13	4c. County	of Death	7.23	
	LXamin	CI.	Spa Creek Center	Annai	polis		Anne	Arun	del	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth			place (State o	or Foreign
	Director		578-40-7928 1XDM 2□F 71 YI	s. Months Days	Hours Min.	7-22-19	33		ingtor	
	ъ		Usual Residence of Decedent							
	rylan	_	10a. State 10b. County 10c. City, Town					1	0d. Inside C	
	e Ma	cto	Maryland Anne Arundel E	dgewater					1 L Yes	2 X No
	or 28	Oire	10e. Street and Number	10f. Zip Code	0.27	10	og. Citizen of V		ntry?	
	ath w	by Funeral Director	1502 Lee Way		037			SA		
	tems	nne	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of If If Yes, specify Cub 	Hispanic Origin? (Spa an, Me xican, Puerto	ecify Yes or No- Rican, etc.)		e - Am <i>e</i> rio k, White,	an Indian, etc.	
36	or l	Ϋ́	1 ☐ Nøver Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes ZXNo	Specify:		Specify	: Wh	ite	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. other then "neturel", or Items 23a or 28e-f show ent, the Madical Examinar must be notified at	d b		ecedent's Usual Occup	nation		16b. Kind of Bu	sinoas/In	duates	
<u> </u>	n 72 "ne"	Completed	(Specify only highest grade completed)	Give kind of work done ife. DO NOT use retire	during most of work.	ing	IOD. KING OF BU	2111622/111	uusiry	
7	withi ene. then	mc	Elementary/Secondary (U-12) College (1-40r 5+)	hanic	-,		Sheet	Meta	1	
7	filed Hygi sther	Ö	17. Father's Name (First, Middle, Last)	Harric	18. Mother's Name	e (First, Middle, N				
Maryland	d be ental	To Be	Walter Belt		Glad	dys Brown	n			
7	Shoul Mari	-		Mailing Address (Street				State, Zip	Code)	
Š	od 2 lith a 27 is r treu		Arlene E. Belt/ Wife 15	02 Lee Way	Edgewate	er, MD 2	1037			
ē,	Hea Hea Item othe		20a. Method of Disposition 20b. Place of Disposition	Disposition (Name of crematory or other pla	- !	Date 2	20c. Location -	City or To	own, State	
30	Page ent o nt: If y or		1 M Burial 2 Cremation 3 Bemoval from State	nt Cemetery		05	Davids	onvi]	lle, M	D
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23a or 28e-f show any injury or other treumetic event, the Medical Examiner must be profitted at once.		21. Signate of Funeral Service Licensee	22. Name and Addre		orge P. I	Kalas F	uner	al Hom	ne
Ã	permi Depa Impo any ir		Volunt 1/ Wel	2973 Solo						
			23a. Part1. Enter the disease, or complications that caused the death. Do no				_ 	Ť	Approximat	te
			shock, or heart failure. List only one cause on each line. Immediate Cause (Final	Call Fall	1				Interval Bet Onset and	
	Pnysician /Medical		disease or condition resulting in death) Due to (or as a consequence of	10 mg 0 mi)	00-6				مل زيد	
r	Examiner		1	ind fai)	Livoris			.	240	
		je	Sequentially list conditions, if any, leading to immediate gauss. Enter Underlying		, , , , ,					
	uted d ansit	Examiner	Cause (Disease or injury that initiated events							
ó	exec en an rial-tr	Exa	resulting in death) Last Due to (or as a consequence of):						
8760,	death certificate be executed e attending physicien and of for use as the burial-transit	cai	d							
9	rtifica ng ph as th	Med	IF FEMALE.							
ŏ	death certifica attending ph d for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 ☐Ectopic pregnanc	ev.			e of delive	-	.,
œ.	deat	Sicis	1 Yes 2 No 4 Pregnant at time of death	5 Other (specify)	,		Mor	nth	Day '	Year
P.O.	Physicien: The law requires that the de this certificate has been signed by the a ral director, page 2 should be detached f	Physician/Med	9 Unknown			-				
	res tha igned be det	by F	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause giv	ven in Part I.	_	acco use contr			
ord	w require been si should I	ted				1 L Ye	s 2 HNo	3 ∐ Prob	ably 4 ⊡t	Jnknown
Records,	e law r has be je 2 sh	Completed				24a. Was ar autopsy		Vere auto	psy findings	available
	Physiclen: The this certificate har al director, page	OIL				perform	ned?	eath?	2□ No	
ita	iclen: Th certificate rector, pag	Be (25. Was case referred to medical examiner?		26. Place of Death	Check only one	9)			
Ž	hysic his ce I dire	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	atient 3 DOA		me 5□Reside	nce 6 □Othe	er (Specif	y)	
n o	ding Phys I. After this funeral di	:uo	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tir (Month, Day Year)	ury Wo		28d. Describe ho	w injury occurr	ed		
Sio	Attending ir death. ector: After by the fune	cati	2 Accident Investigation]Yes 2□No					
Division of Vital	l or Attendatter deatl Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office		28f. Location (Str City or Town		er or Rura	il Route Num	iber,
	urs al erel D				N N					
	Hose 24 ho Fune Fune	edical	29a. Certifier Certifying Physician: To the best of my knowledge, (Check only 2 Medical Examiner: On the basis of examination and/	death occurred at the ti or investigation, in my o	me, date and place, opinion, death occurr	and due to the ca ed at the time, da	use(s) and ma ite and place, a	nner as si ind due to	lated. o the cause(s	>)
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Atter completely filled in by the funer	Med	29b. Signature and title of bertifier	29c. Licens	se number	29	d. Date signed	(Month.	Day, Year)	
	7 ¥ √ 8		Current () Ka							
•			20 Name and address of some who completed arrives of death (flow 200) (7	Una Brieri			J 11 06	YWJ		
			30. Name and address of therson who completed cause of death (Item 23a) (T	Donah (32636 2 ive c	Liter 1	16 cm	1,10		
	Sta	te	31. Date filed (Month, Day, Year) 2. Registrar's Signature	1				41/		
	Registr		MAY 1 7 2005	naug)						

DHMH 17 Rev 1/2001

Registrar

			For State	State of Man		artment of H			- 21	The coto	10000
			Registrar 1. Decedent's Name (First, Middle,	(act)		tillicate of t	Dealli	2. Date of Deat	∍g. No. €., €. h		3. Time of Death
	Physici /Medic		WILLIAM	S. C	HRISTO			Month 0 5	15 2	Year 2 0 0 5	12:25 P _M
	Examin	er	4a. Facility Name (If not institution,			Salisbu	r Location of Death		4c. County	or Death	
	Funeral		Wicomico Nur 5. Social Security Number		In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthpla	ace (State or Foreign
li s	Funeral Director		215-26-3926	M 2□F	3 2 Yrs.	Months Days	Hours Min.	(Month, Day,	- 23	Count	mo mo
	pu »		Usuel Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or Lo	ocation				10	d. Inside City Limits
	tarylan show	ō	(1 Yes 2 No
7	the M	Director	10e. Street and Number	omico	JAL	10f. Zip Code		1	Og. Citizen of \	What Count	ry?
0	within 72 hours after death with the Maryland she." 306. "Han "natural", or Items 23a or 28a-f show he Madical Examination invitiod at	i Di	521-ALARA	ama AVE		21	801		L	ISA	
0	death	Funerai	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecrfy Yes or No- Rican, etc.)		e - America	
400	s after dea	by Fu	1 Never Married 2 Marrie	d 1 TYes 2 No		1 ☐ Yes 2 No	Specify:		Specif		Ark
1215-0036	hours tural		3 ☐ Widowed 4 ☑ Divorced 15. Decedent's	Year or Dates: 4	16a, Dece	dent's Usual Occup	ation		16b. Kind of B	usiness/Ind	ustry
> 2	nin 72 In "na Medic	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of work d)	ing			•
7 5	filed with Hygiene other the	Com	6	30.10 3 0 (1.10.101)	H	MYDURA					PLOYED
	be file d oth event	Be	17. Father's Name (First, Middle, La		V		18. Mother's Name	e (First, Middle, I	Maiden Suman	ne)	
3 3	2 should be filed within 72 hours and Mental Hygiene. Is marked other than "natural", aumatic event, the Madical Exa	ို	19a. Informant's Name Clationshi	CHRISTOP		no Address (Street	and Number or Run	A Poute Number	City or Town	State Zin	Code)
J.H.am C			0	EWS ~ DAVEHT		0-Some	()	CRISE	ern A	C al	18 17
= 0	es 1 and of Health f Item 27 r other tr		20a. Method of Disposition		20b. Place of Dispo			-	20c. Location -	City or Tox	vn, State
7	Pages nent of ant: If It		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		MD VA	CEMETE	- 1 - 1-	3 05	HURLO	CK.	MD
Baltimore	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Li	censee	2	2. Name and Addre	ss o Facility	ENDIE	Smi	TH	F/H
	20549		23a. Part1. Enter the disease, or o	La Thre	o doub Do not on	17-W. I	SABELL	A ST.		BURY	MD 21801
	200		shock, or heart failure. List o	nly one cause on each line.		ter the mode or dyn	ig, such as cardiac	or respiratory arr	551,		Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. TYPOTE Due to (or as a co	consequence of):						
	Examiner			100 00 60	ASTROINTES	TINAL	T	BLEET			
	P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a d	consequence of):						
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	consequence of):					-	
760	be executed sicien and burial-transit	caiE		200 10 (01 23 2 0	sorisbyabilob orj.						
8	ificate g phy: as the			d							
2	th cert endin	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2	pregnancy Fetal death 3[Ectopic pregnancy	<i>y</i>			te of delive	
C	that the death certifica	ysici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at tin 9□Unknown	ne of death 5 [Other (specify)	<u> </u>		Wit	жи	Day Year
Oivision of Vital Becords DO Box	Attanding Physician: The law requires that the death certifical death. • ctor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as it	Completed by Physician/Med	Part II. Other significant condition	as contributing to death but	not resulting in the u	inderlying cause giv	ven in Part I.	23e. Did to	pacco use con	tribute to th	e cause of death?
ž	w requires that is been signed to should be detailed.	ted	TYPE Z	DIABE	TES.			1 🗆 Y	s 2□No	3 Proba	ably 4 Dunknown
2	e law r has be	nple	ANEMIA	ž.				24a. Was a autops perfor	y	Were autop prior to con death?	sy findings available
7	The icate r, pag	Co	PENAL	INSUFFIC	CIENCY	•		1 ☐ Yes	2 No	1 Yes	2 D No
*	sicial s certifi	o Be	25. Was case referred to medicat examiner? 1 Yes 2 No	Hospital:	2 ER/Outpatie	ot 3 DOA Oth	26. Place of Deat	h <i>(Check only or</i> ome 5 ☐ Resid		er (Snecity	1
Ž	g Phy garhis Terthis	n: T	27. Manner of Death	28a. Date of Injury				28d. Describe h			,
	ttendin death. ctor: Afr	atio	1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	ation		M 1 🗆	Yes 2 □ No				
j	or Att	Certification; To	3 Suicide 6 Could not determine	28e. Ptace of Injury building, etc.	/ - At home, farm, st (Specify)	reet, factory, office		28f. Location (S City or Town		ber or Rurai	Route Number,
	spitel		29a. Certifier 1 Certifying	Physician: To the best of	my knowledge, dea	th occurred at the tir	me, date and place,	and due to the c	ause(s) and m	anner as st	ated.
	To the Hospitel or Attanding Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the tuneral director, page	Medical	(Check only 2 Medical E	xaminer: On the basis of each manner state	xamination and/or in	nvestigation, in my o	opinion, death occur	red at the time, d	ate and place,	and due to	the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	1 .17	- 1	29c. Licens	se number	2	9d. Date signe	d (Month, L	Day, Year)
	B. 18,		Malu	MUVI	140	N -	006051.	3	0/16	103	-
	38		30. Name and address of person v	mo completed cause of dea	кп (item 23a) (Туре	, Print)	24 - 2	4 to a con	g fr	100	215/16
		ate	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	1		16131311	/	- 1	/6.)
	Regist	rar	MAY 1	7 2005 Slave	N & A	park					

			r lease 1	• •		nent of Health and	-	•	
			for State Registrer	State of Marytan		cate of Death		g. No. 005	18370
			Decedent's Name (First, Middle, Last)			0.1	2. Date of Death)	3. Time of Death
	Physici /Medic		Darnell	EMErS	on (hase	Month	12, 2005	
	Examin		4a. Facility Name (If not institution, give s	treet and number)	~ _ 4b.	City, Town, or Location of Dea	ath /	4c. County of Death	,
	<u> </u>		2/2-Meteor		105	Jnder 1 Year If Under 24 Hr	-	Dorche	
	Funeral Director		5. Social Security Number 6. Sex	M 2□F Age (III VIS.	Yrs. Mo	nths Days Hours Mir			hplace (State or Foreign untry)
			Usuel Residence of Decedent					9113 101	ary land
\sim	arylan show	_	10a. State 10b. County	10c. Cit	ty, Town or Location	n			10d. Inside City Limits 1 1 Yes 2 □ No
Y	88a-f	ecto	10e, Street and Number	ester	Camil	oridge		- China - (Mhailean Ca	
Z	a or 2	D.	2 1 - 1 1	va Pat s	7/15- "	7. ZIP COOP	10	g. Citizen of What Co)
2	ns 23	Funeral Director	11. Marital Status	12. Was Decedent Ever in U	.S. 13. Was	Decedent of Hispanic Origin? (, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Ame	
9	or ita	Fur	1 Never Married 2 Married	Armed Forces? 1 TYes 2 No If Yes, Give 197		, specify Cuban, Mexican, Pue 'es 2D No <i>Specify:</i>	ino Hican, etc.)	Black, White	
003	ural;	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates: 19	82		1	101	ack
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-1 show the Mudical Examinar must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give kind	: Usual Occupation of work done during most of w OT use retired)	orking	6b. Kind of Business/I	Industry
12	l withii lene. r than	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		ouseman	C	20Smetic	Company
שַׁל	be filed tal Hygi d othar evant.	Bec	17. Father's Name (First, Middle, Last)				ame (First, Middle, M		
ylar	Menta Menta arkad	ToE	EMERSON	W. John	uson	Elo	se C.	Chase	0
Maryland	2 sho	qi.	19a. Informant's Name/Relationship (Typ	oe, Print)		dress (Street and Number or F		City or Town, State, Z	
	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If itam 27 is marked other then "natural", or itams 23s or 28s-f show or other treumatic event. It is Marcical Examinar must be notified at		20a. Method of Disposition	SMith 20b. F	2/2 Me	(Name of	pt, 705 (Oc. Location - City of	E/1D, 21613
nor	Pages nent of I int: If its iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cometery, cremator	y or other place)	21/05	ambrida	
Baltimore,	그 분 원 글		21. Signature of Funeral Service License	The second secon	22. Na	me and Address o Facility			e, MD.
ä	Deparement Deparement		Danelle C	" Henre	1 510	Winsh noton	1 Home, P.	ubridge.	MD. 2/6/13
			23a. Part 1. Enter the disease, or complication of sheek, or heart failure. List only on	cations that caused the delay	h. Do not enter th	mode of dying, such as cardi	ac or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Kenal	Cell C	arcinoma			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):				
		er	Sequentially list conditions, b	Due to (or as a consec	uerice of):				
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
oʻ	sician and burial-transit		resulting in death) Last	Due to (or as a consec	quence of):				
8760	× × ×	lical							
x 68	death certificat e attending phy ed for use as the	/Med	IF FEMALE:	3c. If yes, out <i>come</i> of pregna	ancy			204 0-4-4-4	
Вох	atten for us	clan	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of c	al death 3 □Ecto	pic pregnancy er (specify)		23d. Date of deli Month	Day Year
o.	0 0 0	Physiclan/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		, , ,			
S, P	The law requires that the tte has been signed by the bage 2 should be detache	by P	Part II. Other significant conditions con	tributing to death but not res	sulting in the under	ying cause given in Part I.		acco use contribute to	
ord	w require been si						1 ☐ Yes	s 2 No 3 Pro	obably 4 Munknown
ec	elawi hasbo je 2 sh	ompleted					24a. Was an autopsy perform	prior to c	topsy findings available completion of cause of
Vital Records,		O					1 ☐ Yes 2	✓ No 1 ☐ Yes	2 □ No
Zit.	0 9	o Be	25. Was case referred to medical examiner? 1 Yes 2 Markon	lospital: 1 Inpatient 2	IED/Outpationt 2	Other	eath (Check only one	nce 6 □Other (Spec	264
of		-	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury at Work?	28d. Describe how		ouy)
ion	Attending I r death. actor: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	1 Yes 2 No			
Division	or Attendation of Attendation Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fy)	actory, office	28f. Location (Str. City or Town,	eet and Number or Ru . State)	iral Route Number,
	Hospital or the hours afte Funeral Dirately filled in t		CO. Cartillar 15 Cartifular Phys	rinian. To the best of mules		want at the time date and ale	and due to the sec	uno(a) and manner as	etatad
	To the Hospital or Atte within 24 hours after de To tha Funeral Diracte completely filled in by the	edical	29a. Certifier 1 ▼ Certifying Phys (Check only 2 ■ Medicel Examin one)	ner: On the basis of examina and manner stated.	ation and/or investi	urred at the time, date and pla- gation, in my opinion, death oc	curred at the time, da	te and place, and due	to the cause(s)
	within 2 To the complet	Me	29b. Signature and title of certifier	2//		29c. License number	29	d. Date signed (Month	h, Day, Year)
})///	- mo)	057290		5/16/05	
			30. Name and address of person who co	mpleted cause of death (Iter		503 A Muri	401	A WM 3'	11.12
			31, Date filed (Month, Mar) 1 7	20032. Regionar's Signa	ature 2	202 H 160C	IT. Compr	vy, rv) 1	
	Sta Regist		48741" A. (2001	and the same				

			1 - For State Registrar	State of Mar		artment of I			ene g. No.2 0 0 5	18371
	Physic /Medi		1. Decedent's Name <i>(First, Middle, Last</i> Karen Marie Chi					2. Date of Death Month May	Day Year 14 2005	3. Time of Death 12:05 PM
	Exami		4a. Facility Name (If not institution, give 243 Benton Pleasu	re Road		C	or Location of Deat hester	h	4c. County of Deat	
	Funeral Director		5. Social Security Number 6. Se 217–92–1119 Usual Residence of Decedent	x 7. Age (i □ M 2⊠ F	In yrs. last birthday, 41 Yrs.	Months Days			9. Birtl 4, 1964 F	hplace (State or Foreign untry) Rhode Island
	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It was a second them 27 is marked other than "natural", or items 23e or 28e-f show other traumetic avent, the Medical Exercipar must be notified at	Irector	10a. State 10b. County Maryland Queen A 10e. Street and Number	nne's	Oc. City, Town or L		ester	10	g. Citîzen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☐ No untry?
9	after death wi or items 23e o	by Funeral Director	243 Benton Pleas 11. Marital Status 1 Never Married Married	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 227No	er in U.S. 13.		21619 Hispanic Origin? (S Jan, Mexican, Puert	pecify Yes or No- o Rican, etc.)	U.S.	ncan Indian, a, etc.
Maryland 21215-0036	n 72 hours "natural", c	leted by	3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grad	If Yes, Give Year or Dates: Ication le completed)	16a. Dece	dent's Usual Occup		king	Specify: Wh	
d 212	2 should be filed withir and Mental Hygiene. is marked other than aumetic avent, Ira.M.	Be Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5+)		ntal Assi	istant	ne (First, Middle, Ma	Dentis	stry
arylan	should be ind Mental imarked c	To B	Phillip Cook, Sr. 19a. Informant's Name/Relationship (Ty	vpe, Print)	19b. Maili	ng Address (Street		cia Alvar	nus City or Town, State, Z	ip Code)
	es 1 and 2 of Health a f Item 27 is r other trai		Frederick Child 20a. Method of Disposition 1 □ Burial 2 Cremation 3 □ F		243 20b. Place of Dispo	Benton Pl	leasure R	oad Ches	ter, Maryl	and 21619
Baltimore,	permit, Pages 1 and. Department of Health Important: If item 27 any injury or other tr 20059.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	ام	Baltimor 2	e Cremato 2. Name and Addre	ory 5/1 ess of Facility J	ohn M. Ta	Baltimore, ylor Funer	Maryland ral Home , MD 21401
8760,	cate be executed //Medical by Scian and purial-transit the burial-transit	dical Examiner	23a. Part1. Enter the disease, or compl shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	e death. Do not en Lial Tumo onsequence of): onsequence of):	ter the mode of dyir	ng, such as cardiac	or respiratory arres	it,	Approximate Interval Between Onset and Death 5 years
O. Box 6	law requires that the death certifica as been signed by the attending pl 2 should be delached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2X No 9 □ Unknown	3c. If yes, outcome of p 1 Live birth 2 C 4 Pregnant at tim 9 Unknown	Fetal death 3	Ectopic pregnancy	у		23d. Date of deliv Month	very Day Year
ecords, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions con	ntributing to death but n	ot resulting in the u	nderlying cause giv	en in Part I.		cco use contribute to	the cause of death?
Vital Reco	The ate h	Completed						24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
of Vit	Physician: ' this certifica	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒No 27. Manner of Death		2 ER/Outpatier	Partition	er: 4 Nursing H		ce 6 □Other (Speci	(ty)
Division	tending leath. tor: After the funer	Certification;	***DEX**Natural 5	28a. Date of Injury (Month, Day Ye 28e. Place of Injury building, etc. (S	- At home, farm, str	M 1 🗆	y at k? Yes 2 □ No	28f. Location (Stree City or Town, S	et and Number or Rur	al Route Number,
	Hospita 4 hours Funeral ely filled	ledical Ce	29a. Certifier (Check only one)	sician: To the best of more: On the basis of exa	am≀nation and/or in	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the caus	se(s) and manner as s a and place, and due t	stated. o the cause(s)
	To the within 24 To the formulation complete	Me	29b. Signature and ville of certifier	Unt	~	29c. Licens D081			Date signed (Month, May 16, 20	**
			30. Name and address of person who co Stanley Watkins	mpleted cause of death 900 Bestga			napolis,	MD 21401		
•	Sta	- 2	31. Date filed (Month, Day, Year)	37 Registrar's		act i				

			1 - For State Registrar	State of Ma	ryland .		artment o			•	gien Reg. N		183	172
	Dhusis		1. Decedent's Name (First, Middle, Las	t)						2. Date of De			3. Time of	f Death
	Physic /Medi		Charles		Α.	Coa	tes			Month May 14	Da	2005	3:14	ΔΜ
	Exami		4a. Facility Name (If not institution, give	street and number)			4b. City, Tow	n, or Loca	ation of Dea	th	40	. County of Death	J. 1	- 11
		Â	Charlotte Hall V				Char1				_ ;	St. MARY'	S	
п	Funeral		5. Social Security Number 6. Se	20 M 20 E	(In yrs. last		If Under 1 Ye Months Da	ear If U	Inder 24 Hr		th v. Year	9. Birthpl	ace (State o	or Foreign
Н	Director		Usual Residence of Decedent	70	0	Yrs.				Novembe	r 3	Washi	ngton	,DC
	land w		10a. State 10b. County	T.	10c. City, T	own or Lo	cation					110	Od. Inside C	its Limite
	Mary	ō	MD Prince G		,									2 □ No
	28a	Director	10e. Street and Number	eorge s	Lidi	nham	10f. Zip Cod	10			10a Ci	tizen of What Coun		
	3a oi	ā	7934 Dellwood Av	enile				706			-		uy r	
	death	Funeral	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. \			ic Origin? (Specify Yes or No.		S.A.	an Indian	
9	after or ita	Ē	1 Never Married 22 Married	Armed Forces? 1 ☑ Yes 2 ☐ No	,				exican, Puè	Specify Yes or No- to Rican, etc.)		Black, White, e		
03	rat', c	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2🖾	No Spe	ecify:			Specify: Bla	kck	
21215-0036	e filed within 72 hours after death with the Maryland if Hygiene. other than "natural", or frams 23a or 28a-f show vant, If a Medical Evantifier must be inclined at	Completed	15. Decedent's Edu (Specify only highest grad	ication	10	6a. Deced	ent's Usual Oc kind of work do	cupation		4.1-	16b. K	ind of Business/Ind	ustry	
7	ithin Ban	du	Elementary/Secondary (0-12)	College (1-4or 5+))	life. L	OO NOT use re	tired)	most of wa	irking				
	ed w ygier ygier ygier tr	S	llth l		A	dmin	istrati					Governmen	it	
nu	be fil Ital H Id otl	Be	17. Father's Name (First, Middle, Last)							me (First, Middle,	Maiden	Sumame)		
<u>\\</u>	ould Men Marka Marka	မ	Howard Coates							ne Lewis				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-1 show any injury or other traumatic avant, the Middel Evantiral must be inclifted at ance.		19a. Informant's Name/Relationship (7)	•	1.0							or Town, State, Zip	Code)	
	t and tealth am 27		Frances Coates/Wi						renue	Lanham,			706	
Baltimore,	ges If of h		1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	ceme	etery, crem	sition (Name of natory or other)	place)	1	Date	20c. L	ocation - City or Tov	vn, State	
菲	t. Pa rtmen rtant: rjury	1 7	`4 □ Donation 5 □ Other (Specify)		Mary		Vetera			3/05	Che1	tenham,Ma	rylan	d
Bal	Depariment of the policy of th		21. Signature of Furieral Service Licens	88			Name and Ad			J. B. Jen	ıkin	s Funeral	Home	
_	462 6 0			3		74	74 Lan	dover	r Road	Landove	r,	Maryland	2078.	5
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	ications that caused th ne cause on each line.	ie death. D	o not ente	r the mode of o	dying, sucl	ch as cardia	c or respiratory arr	rest,		Approximate Interval Bety	ween
	Physician /Medical	(6 J	Immediate Cause (Final disease or condition resulting in death)	Metast	catic	Colo	n Cance	er					Onset and D	Jeath
	Examiner			Due to (or as a c	consequenc	ce of):								
	2 2 2 2	2	Sequentially list conditions, if any, leading to immediate	Due to (or as a c	consequenc	ne off).								
	uted f insit	nin.	cause. Enter Underlying			50 01).								
,	n and	Examiner	that initiated events resulting in death) Last	Due to (or as a c	consequenc	e of):					_			
58760,	ficate be executed physician and s the burial-transit	dical		1 =										
_	tifica ig ph as th	led												
ŏ	death certifi e attending i id for use as	an/N	The state of the s	3c. If yes, outcome of a	pregnancy	th all						23d. Date of delivery	,	
B	0 0 0	sicie	in the past 12 months? 1 \subseteq Yes 2 \subseteq No	4 Pregnant at tim			Ectopic pregnal Other <i>(specify)</i>					Month E	ay Y	'ear
o.	at the de by the a stached	Physician/Me	9 🗆 Unknown								1			
Ś	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions cor	tributing to death but r	not resulting	g in the un	derlying cause	given in P	Part I.	23e. Did tol	bacco u	se contribute to the	cause of de	ath?
ecords,	w require been signature should b	ted								1 □ Y€	es 2[□No 3□Probab	oly 4 ∰Ur	nknown
ပို	e law r has be je 2 sh	Completed								24a. Wasa		24b. Were autops prior to comp	y findings a	vailable
r	ate pag	OU								autops perforr	ned? 2∑∷No	death?	pletion of ca. ∰No	use of
VItal	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?					26. P	Place of Dea	th (Check only on		10163 2	<u>₽₽</u> 140	
OI V	hysic his ce I dire	2	1 Yes 2 XNo	ospital: 1 Inpatient	2 🗆 ER/0	Outpatient	3□ DOA	Other: 4	Nursing H	ome 5 🗆 Reside	ence 6	Other (Specify)	Hosp	ice
		ü.	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	e <i>ar)</i> 28b	. Time of Injury	28c. in		-	28d. Describe ho				100
<u>0</u>	Attending or death. sctor: After by the fune	Sati	2 Accident investigation					☐ Yes 2	2 □No					
	al or Attency after death Diractor: d in by the	ertification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (5	- At home, Specify)	farm, stree	et, factory, offic	:0		28f. Location (St. City or Town	reet and	d Number or Rural F	Route Numb	er,
_	spital ours at naral D	O												
	E 4 P E	edical	29a. Certifier (Check only one) 1 ☐ Certifying Phys 2 ☐ Medical Examir	ician: To the best of m		ge, death and/or inve	occurred at the stigation, in my	time, date y opinion,	e and place death occu	, and due to the ca	ause(s) ate and	and manner as stat	ed. ne cause(s)	
	To tha Hos within 24 h To tha Fur completely	Mec	29b. Signature and title of certifier	and manner stated	J.			nse numb				signed (Month, Da		
	-3+8		DAI/ 1/	1/1-	A		د میں	111	وسهما	,	Dale	July Indiana (Month, Da	y, rear)	
	(0)	-	30. Name and address of person who co	moleted source of the	h (ltc= 22	\ (T:- ~	mo	46	> 4/		5/	16/05		
_	9	ĺ	Ndubisi Achufusi					lena:	rden.	Marvlana	1 20	706		
	Stat	e	31. Date filed (Month, Day, Year)	2. Registrar's	Signature.					TIGIT J Lain		, 00		
	Registra		MAY 1 8 2005	Feed		hour	000							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM #5 PER INF (28/4/16/06/05) III Health and Martel Heritage Co. Co.

			1 - For State Registrar	"Slate" Mary		rtificate of			giene () 5 Reg. No.	18373
	Physici		Decedent's Name (First, Middle, Last) James A.	Douglas				2. Date of Dea	Day	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give			4b. City, Town, or	r Location of Death	May	15 20.	
			Peninsula Legiona	1 Nedical	Center	Sali	Shucu		Wicon	
	Funeral		5. Gogial Sequeity Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h	Birthplace (State or Foreign
	Director		2 26-30-315 4	M 2□F 87	Yrs.	Months Days	TIOUIS IVIII.	8. Date of Birt Month, Da 2/5/19	18" 1	North Carolina
	and w		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Lo	ocation		-		10d. Inside City Limits
	Mary -feh	ţ	Maryland Wicomico		Sali	sbury				1 X Yes 2 □ No
	r 28e	Director	10e. Street and Number		Dair	10f. Zip Code			10g. Citizen of Wh	nat Country?
	d within 72 hours after death with the Maryland jaene. r than "netural", or itema 23a or 28e-f ehow the Modeal Examiner must be incitified an		1503 Winthrup Pla	ace		218	04		USA	
	ema err	Funeral	11. Marital Status	12. Was Decedent Ever	n U.S. 13.	Was Decedent of H	ispanic Origin? (Spen, Mexican, Puerto	ecify Yes or No-	14. Race	American Indian,
36	or It	by Fu	1 Never Married 2 Married	1 XYes 2 No		1 ☐ Yes 2 🕱 No	Specify:	riican, etc.)	Specify:	White, etc.
21215-0036	hour tural	d be	3 Widowed 4 Divorced	Year or Dates: Arm	ιλ					white
15	C * -	Completed	(Specify only highest grade	completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of worki i)	ing	16b. Kind of Busi	ness/Industry
212	ifled within 'I Hygiene. other than "	E O	Elementary/Secondary (0-12)	College (1-4or 5+) -	1	Chief	,		Fire Fi	ahtina
	e filed al Hygi l other vent, L	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,		
Maryland	Menta Menta Brked	20	James A. Dougla	ıs			Eva McUt	ling		
lan	2 sho and le mu	- 6	19a. Informant's Name/Relationship (Type	-	19b. Mailir	ng Address (Street a	and Number or Rura	I Route Numbe	r. City or Town, St	ate, Zip Code)
	l and lealth om 27 har tu		Mildred M. Douglas		1503	3 Winthru	Place,	Salisbu		
Baltimore,	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R		b. Place of Dispo cemetery, crer	natory or other place Memorial	θ))ate	20c. Location - Ci	
Ħ	it. Parturber		* 4 ☐ Donation 5 ☐ Other (Specify)		Park		5/18	12	Salisbu	
Ba Ba	Depar Impo Impo any ir		no ho bell	lo		DUI SHOW I	HILL KO.	Salisb	urv. MD 2	l Association 21804
п			23a. Pax1. Enter the disease, or complications, or heart failure. List only on	cations that caused the decause on each line.	eath. Do not ent	er the mode of dying	g, such as cardiac c	or respiratory ari	rest,	Approximate Interval Between
	Physician	Ì	Immediate Cause (Final disease or condition	assi	ratio	in Po	reunne	ma		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):					
H		-	Sequentially list conditions,	Due to (or as a con-	sequence of):					
	uted Insit	min	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	540 10 (01 40 4 50)	304401100 017.					
Ć	exection and ital-tra	Examiner	that initiated events c resulting in death) Last	Due to (or as a con	sequence of):					
68760,	tificate be executed g physician and as the burial-transit	edicai	U d							
			IF FEMALE:							
Вох	attending for use	lan/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F	etal death 3	Ectopic pregnancy			23d. Date of	,
0	The law requires that the death cer tie has been signed by the attendir page 2 should be detached for use	Physician/M	1 Yes 2 No	4□Pregnant at time of 9□Unknown	of death 5	Other (specify)			Month	Day Year
<u> </u>	that the de led by the a detached f	Ph	Part II. Other significant conditions con	tributing to death but not	resulting in the u	nderlying cause give	on in Part I	23e Did to	hacco use contribu	ute to the cause of death?
Records,	uires sign Id be	d by		• • • • • • • • • • • • • • • • • • • •		identy ing dadde give				Probably 4 Wonknown
COL	w requir been si should	ete						24a. Was a		
Re	The lav ate has page 2	Completed					-	autops perfora	med? prio	
Viital		0	25. Was case referred to medical				26. Place of Death	1 Yes		Yes 2□ No
<u>></u>	yaici	ToB	examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 Impatient 2	ER/Outpatien	3 □ DOA Othe			ence 6 Other	(Specify)
Division of			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time of	28c. Injury Work	at 2		ow injury occurred	Specify
<u>s</u>	itendi Jeath. tor: A the fu	catl	2 Accident investigation 3 Suicide 6 Could not be				'es 2 □ No			
\leq	or Attendated after death Director:	Certification;	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, stre ecify)	eet, factory, office	2	8f. Location (St City or Town	treet and Number (n, State)	or Rural Route Number,
_	spitat or ours afte neral Dir filled in		29a. Certifier 1 Certifying Physi	icing: To the heat of my	coulodes dest					
	he Hos in 24 h he Fur pletely	edical	(Check only 2 Medical Examin	er: On the best of my er: On the basis of exam and manner stated.	ination and/or inv	estigation, in my op	e, date and place, a inion, death occurre	and due to the ca	ause(s) and manno ate and place, and	er as stated. due to the cause(s)
	To t Com	×	29b. Signature and title of certifier			29c. License		2	9d. Date signed (A	Month, Day, Year)
	809,			\rightarrow	-00	(40	057410	7	5/16/0	15
	die		30. Name and activess of person the core 5 Imona.	ipleted cause of death (I	tem 23a) (Type, 1 Eas +	Carroll S	street	Salish	un, mo	121801
	Stat Registra	- 1	31. Date filed (Month, Day, Year) MAY 1 7 20	32. Angistrar's Sig	gnature	and a				

		1 - For State Registrar				and / Dep		Health and	Mental Hy		one	18371
		1. Decedent's Name (First,	Aiddle, Las	t)					2. Date of D	eath		3. Time of Death
Phys /Me	sıcıa edica	Mary Max							Month Mav	Day	Year 2005	9:25 p м
r e	mine	4 27 101 11 115					4b. City, Town,	or Location of De			County of Death	
		1000 Locu		-	3			ridge			Dorches	ster
Fune Direct		5. Social Security Number 216–36–7060 Usual Residence of Decede		x □ M 25 X F		rs. last birthday)	If Under 1 Yea Months Days			rth ay, Yea <i>r)</i> 3 , 19	9. Birth Cou 139 Ker	nplace (State or Foreign Intry) Itucky
iryland thow		10a. State 10b. C	unty		10c.	City, Town or Lo						10d. Inside City Limits
the Ma 28e-f s		MD Do	orches	ster			Ca 10f. Zip Code	mbridge		10- 01-		1 XYes 2 No
with		1000 Tom	- C+	7 L	2		101. Zip Code	04.64.0			en of What Cou	intry?
Jeath ms 2:		1000 Locus	L SL.	12. Was Dece		U.S. 13.	Was Decedent of	21613 Hispanic Origin?	Specify Yes or N	US	A 4. Race - Amer	ican Indian
Defillingtey, IMaryliand ZIZI3-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or items 23e or 28e-f show any injury or other treumatic event, The Medical Event agreements.	ı	MD Do 10e. Street and Number 1000 Locus 11. Marital Status 1 Never Married 2 3 Widowed 4 Div. 15. Dec (Specify only) Elementary/Secondary (0		Armed For 1 ☐ Yes If Yes, Giv Year or Da	ces? 2 ⊠ No e		If Yes, specify Cui 1 ☐ Yes 2 🕱 No		(Specify Yes or No arto Rican, etc.)		Black, White	ite
Maryland ZIZIS-UU36 Id 2 should be filed within 72 hours aft th and Mantal Hygiene. Ty Is marked other then "neturel", or treumalic event, Ter Medical Event		15. Dec	edent's Edi	ucation		16a. Dece	dent's Usual Occu	pation		16b. Kin	d of Business/Ir	ndustry
iffin a		(Specify only in Elementary/Secondary (0		College (1	4or 5+)	life.	DO NOT use retin	*	orking	-	-	
C Z IZ		5 11					catere				od serv	rice
be find tall H and ott		17. Father's Name (First, Mi							ame (First, Middle	, Maiden S	Sumame)	
2 should be and Mental is marked of eumatic eve	F	Charles M.				-			a Black			
Man d 2 sl h an 7 ls r treur	4	19a. Informant's Name/Rela							Rural Route Numb		Town, State, Zi	p Code)
1 and 1 Health tem 27		Vanessa Mille 20a. Method of Disposition	r gr	anadaud		2918 Place of Dispo	Pungy P	ath, Cam	bridge, I		1613 ation - City or T	inum Otata
Pages nent of lint: If its		1 ☐ Burial 2 🕱 Crema	ion 3 □f	Removal from S	naio		sition (Name of natory or other pla					
Datumore, permit. Pages 1 au Department of Hea Importent: If item any injury or othe		*4 □Donation 5 □Oth			S			ory 5/1			sbury,	
Depril Depril	once	R	R			10.00	. Name and Addr		Thomas Fr			P.A.
		23a. Part1. Enter the disease shock, or heart failure.	e, or comp	lications that ca	used the de				ambridge		21613	Approximate
ate be executed Wedic Examino hysician and the burial-transit	al er	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	{	Due to (o	or as a cons	equence of): equence of):	he h	lart	diseas			Onset and Death
death certificate be ex eatlending physician ed for use as the burial	Dhysicion/Modical			d 23c. If yes, outc 1 □ Live bii	ome of preg	nancy	Ectopic pregnanc	у		23	d. Date of deliver	•
. 0 000	oioio	1 Yes 2 No		4□Pregna 9□Unkno	int at time of wn	death 5□	Other (specify)				Month	Day Year
uires tha signed d be de	2	Tait ii. Other significant con	ditions co	ntributing to dea	ath but not re	esulting in the ur	nderlying cause gr	ven in Part I.		_		he cause of death?
S S S	pataloud								24a. Was autor perfo	rmed2	death?	ppsy findings available impletion of cause of
	0	25. Was case referred to me	dica!					26 Place of Do	1 ☐ Yes		1 🗆 Yes	2□ No
- > O D	11.5	examiner?	-	lospital:	patient 2	☐ ER/Outpatien	t 3□ DOA Ot		Home 5 President		70thes (00)	-
	Ė			28a. Date of	Injury	28b. Time of	28c. Inju	rv at	28d. Describe I			y)
r Attending F er death. rector: After by the funer	4	1 ☑ Natural 5 ☐ Po 2 ☐ Accident in	estigation	(Worth	, Day Year)	Injury	M 1	rk? Yes 2 □ No				
9 4 5 5	ertification.	3 Suicide 6 Co	uld not be ermined	28e. Place o building	of Injury - At g, etc. (Spec	home, farm, stre	eet, factory, office		28f. Location (3 City or Tox	Street and I vn, State)	Number or Rura	I Route Number,
To the Hospitel within 24 hours a To the Funerel C completely filled	Cledical		fying Physical Exami	sician: To the t ner: On the bas and manne	sis of examir	nowledge, death nation and/or inv	occurred at the ti estigation, in my	me, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) ar	nd manner as si lace, and due to	tated. the cause(s)
To the To the Comp	M	29b. Signature and title of	9	a M	20		29c. Licens	60.5665	G RND4E	29d. Date :	signed (Month,	Day, Year)
		30. Name and address of pe	son who co	mpleted cause	of death (Ite	em 23a) (Type, I	Print)	- Inni	201011	· N	20 - 2	1613
	State	Ot Date Glad (Manth Waste)		2005 ^{32. Re}	rar's Sign	nature	<u> </u>	ر مراه الراص	,,,,,,,	201		
	etrar			AUUU LA	LOS .	(East)	40 -40					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death May **Physician** 13, 2005 Edelgard Rotraud Dietrich 4:15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 825 Coachway Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth Month, Day, Feb. 4, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months Days 1 ☐ M 2 📆 F 64 1941 Director Yrs. 116-34-2853 Germany Usuel Residence of Decedent with tha Maryland 10c. City, Town or Location show 10a. State 10b. County 10d. Inside City Limits item 27 is markad other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examinar must be neithed at Maryland Anne Arundel Annapolis Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 825 Coachway 21401 United States death Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should ba tiled within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iter any injury or other traumatic event, the Medical Evar Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Interior Designer Entrepreneur 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernst Paul Strauss Hildegard Sophie Lipstreich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry H. Dietrich / Husband 825 Coachway Annapolis, Maryland 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Mem. Gardens 5/16/2005 Davidsonville, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician 01106 actoma disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of, Examiner as the burial-transit The law raquires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical attending IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Por in the past 12 months? Day Month Year 5 Other (specify) P.O. | 1 ☐ Yes 2 No 9 ☐ Unknown detachad the 9□ Unknown signad by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 PNo 1 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: 1 | Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death After t Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 2 Accident 5 Pending after death.

Director: Aft investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier completely (Check only one) 29b. Signature and little of certifie 29c. License number 29d. Date signed (Month, Day, Year) 19838 30 Name and address of person who completed cause of death (Item 23a) (Type Print) Bestgate Annapolis, und 2140; 400 Selouicu MO Straut 31. Date filed (Month, Day Signature State

DHMH 17 Rev 1/2001

Registrar

			1 - For State	State of Ma	ryland / Dep	artment of F ertificate of		10.50	6000	18376
			Registrar 1. Decedent's Name (First, Middle, La	st) Ibaald I		Tuncale of	Dealli	2. Date of Death	. No.	3. Time of Death
Ų.	Physici /Medi		Dubbs Han	Harroid I	E. Dubbs			Month 05 1	Day 2005	
	Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	r Location of Death		4c. County of De	
			Atlantic General	Hospital		E	erlin		Worce	ster
	Funeral Director		170-24-9009	ex 7. Age	(In yrs. last birthday 74 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You Oct. 2,	9. 8 1930	irthplace (State or Foreign Country) PA
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	e Maryi	ctor	MD Worces	ter		Berlin				1 ☐ Yes 2 🛣 No
	ath with th 23a or 24 Und be no	Funeral Director	10e. Street and Number 29 Offshore Lane	9		10f. Zip Code 218	11	10g	. Citizen of What C USA	•
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-1 ehow diral Examiner must be redified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent E Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🕱 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - An Black, Wh Specify: W	nite, etc.
5-0	i within 72 hours jene. r than "natural", the Medical Ext	Completed	15. Decedent's Education (Specify only highest gra		16a. Dece	edent's Usual Occup kind of work done	ation during most of work	cina	b. Kind of Busines	•
2	C 38	Пр	Elementary/Secondary (0-12)	College (1-4or 5-	life.	DO NOT use retired	d)	.An	ne Arund	
N 70			17. Father's Name (First, Middle, Last,			Electrici		e (First, Middle, Mai	mmunity	correde
Maryland	be de la la la la la la la la la la la la la	To Be	Clarence H. Dubl				Edna M.	, ,	iden Sumame)	
	d 2 shu th and 7 is m traum		19a. Informant's Name/Relationship (Catherine F. Hai					al Route Number, C erlin, MD	ity or Town, State, 21811	Zip Code)
Baltimore,	Pages 1 nent of H. ant: # iter ury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specification)			osition (Name of matory or other place st Cemete	May	20	c. Location - City of innapolis	
Balt	permit. Pa Departmer Important any injury once.		21. Signature Muneral Service Licer	See Man	.g.	2 Name and Addre arranco & 95 Gov. R	Sons, P.	The state of the s	a Park F a Park.	uneral Home MD 21146
100 mg	3 5		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused to	the death. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arrest,	42.17	Approximate Interval Between
1 304	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a Sepsis	y Tract li	nfection				Onset and Death
68760,	tificate be executed by physician and as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Renal	consequence of): Failure consequence of):					
	ficate p phys	edical		d						
. Box	death cer e attendir d for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	'		23d. Date of de Month	elivery Day Year
	Per Per Per Per Per Per Per Per Per Per	by	Part II. Other significant conditions of Anemia	ontributing to death but	t not resulting in the u	inderlying cause giv	en in Part t.	23e. Did tobac	/	to the cause of death?
Õ	aw requi	lete	Diabetes Mei	litus			,	24a. Was an	24b Ware a	utopsy findings available
		Completed						autopsy performed	prior to death?	completion of cause of
5	sicier certif recto	o Be	25. Was case referred to medical examiner?	Hospital:		ot 30 DOA Oth	or	h (Check only one)		
0	Phys rahdi	\vdash	1 Yes 2 No 27. Manner of Death	1 ⊿ Inpatient		" 3 DOA	4 Nuising Ho	me 5 Residence 28d. Describe how in		ecity)
Division of	ttending F death. stor: After the funer	catlon	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day	Year) Injury	Worl	Yes 2 □ No	200. Describe flow i	injury occurred	
2	itel or At rs after c el Direct ed in by	Certification:	4 Homicide determined	building, etc.				28f. Location (Stree City or Town, S	itate)	
	To the Hospitel or Attending Physicien: within 24 hours after deals. To the Funerel Director: After this certifical completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of liner: On the basis of e and manner state	examination and/or in	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occurr	and due to the cause red at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within To the Comp.	W	29b. Signature and title of certifier	Unnas	my)	29c. License 1956	3/2	29d. 5	Date signed (Mon	th, Day, Year)
	Ī	1	30. Name and address of person who descriptions of the second with the second	completed cause of dea	ath (Item 23a) (Type,	Print) Health	way Drive	e Berlin	, MD 2	1811
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar	's Signature		1	/		J -
	Registra	ar	MAY 1 7 20							

6396-48-861

Dubbs, Harold E

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death	ind Mentarri	Reg. No 2 0 (15 18377
	Physic	ian	1. Decedent's Name (First, Middle, Last)	2. Dete of I		3. Time of Death
	/Medi		Nancy Occhiuto D'Alessio		05/15/2005	8:03 am
	Examir	ner		vn, or Location of Dea	ath 4c. County of	Deeth
			Manor Care - 10714 Potomac Tennis Lane Potom		Montg	
	Funeral Director		5. Social Security Number 087-28-3575 087-28-3575 087-28-3575 087-28-3575 087-28-3575 087-28-3575 087-28-3575 087-28-3575 087-28-3575 087-28-3575 087-28-3575 087-28-3575 087-28-3575 087-28-3575 087-28-3575	Min. (Month, L	Birth (2014) (3) (4) (4) (4) (4) (4) (4) (4) (4) (4) (4	New York
	Aaryland F show	ō	10a. Stete 10b. County 10c. City, Town or Location	_		10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	289-	Director	MD Montgomery Potomac 10e. Street and Number 10f. Zip Code		10. 00:	
	th with 23e or	al Dir	10718 Potomac Tennis Lane 20854		10g. Citizen of What	at Country?
020	72 hours after death with the Maryland natural', or items 23s or 28s-f show dical Evaning must be notified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U,S. Amed Forces? 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U,S. Amed Forces? 1 □ Yes 2 ☑ No If Yes, specify Cuban, Mexican, 1 □ Yes 2 ☑ No Specify:	in? (Specify Yes or N Puerto Rican, etc.)	14. Race - Black, Specify:	American Indien, White, etc. White
21215-0020	n 72 hours "neturel",	Completed	15. Decedent's Education (Specify only highest grede completed) [Give kind of work done during most life. DO NOT use retired)	of working	16b. Kind of Busin	ness/Industry
212	filed within Hyglana. ther than "que, the Med	Comp	12 Homemaker		Own Home	e
Maryland	8 a b >	o Be		's Name <i>(First, Midd</i> i isa Casale	le, Maiden Sumame) :	
	nd 2 should lith and Man 27 is marke r traumatic		19a. Informent's Neme/Relationship (Type, Print) (daughter) 19b. Mailing Address (Street and Number Louise D'Alessio Hof 1577 Hugo Circle, S			
Baltimore,	Pagas 1 annant of Has Int: If Itam:		20a. Method of Disposition 1 Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Date	20c. Location - Cit	y or Town, State
Balt	permit. I Departm Importar any inju		21. Signeture of Funeral Service Licensee Advent Funeral Advent Funeral	Sarvicas	61	
Toda .	Dhysisian		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a shock, or heert failure. List only one cause on each line.	Vay Falls ardiac or respiratory	Church, \ arrest,	A 22046 Approximate Interval Between Onset and Death
*	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Aprication pue to (or as a consequence of):	eumor	ia	WK
	cuted nd ransit	aminer	Sequentially list conditions. b. Organic brain Some Sequence of the conditions of t	pumor prodro	me	YRS
0X 68/60,	certificata be axecuted nding physician and usa as tha bunal-transit	2	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	y dis	ease	YRs.
Ď	daath ce e attandir ad for usa	Cia	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	Oah Die		
, F.C. Box	v raquiras that tha daath cei been signed by the attandir should be datachad for usa	by Physician/	Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in Part I.		Yes 2 No 3	bute to the cause of death? ☐ Probably 4☑ Unknown
Division of Vital Records,	Tha law raquiras that tha ata has been signed by th paga 2 should be datacht	Completed b			s en autopsy 2 ormed?	4b. Were autopsy findings available prior to completion of cause of deeth?
ב ה	n: Tha icata h r, paga			1 🗆	Yes 2/10 No	1 ☐ Yes 2 K No
5	iciai cartif racto	Be c	examiner?	of Death (Check only		
ō	Physical distribution	2	Nurse Nurse		idence 6 Other (Specify)
פוסו	Attending I ir daath. octor: Aftar by the funa	atlon	11 Antural 5 □ Pending (Month, Dey Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No.		how injury occurred	
<u> </u>	tal or Atters as all Directors ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Number o own, State)	or Rural Route Number,
	To the Hospital or Attending Physicien: The law within 24 Mours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	edical	29a. Centifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and 2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	place, and due to the occurred at the time	cause(s) and manne , date and place, and	er as stated. due to the cause(s)
it.	To the Com		29b. Signature and title of certifier 29c. License number		29d. Date signed (N	
			1 X(1) Lac m) D3579	2	MAY. 16	,2005
_			30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) SWAKOOP- G- RAO, SO, W EDMONSTO	NDR. I	20CKVII	LLE, mil
1	Stat	е :	31. Dete filed (Month, Day, Year) 2. Registrer's Signeture		- •	· · · · · · · · · · · · · · · · · · ·

DHMH 16 Rev 6/95

			1 - For State Registrar			Maryla	nd / Depa		t of H	ealth a	and N	•			15	18378
	Physici	an.	Decedent's Name (First, M									2. Date of Month		Day	Year	3. Time of Death
	/Medi		William	Lav	vrence		Eck	les				May	12,	2005	. 021	8:50 P M
}	Examir	ier	4a. Facility Name (If not instit			ber)		4b. City,	Town, or	Location of	of Death			4c. County of	f Death	
			9404 Bruce	Driv	е					Spri	ng			Mon	tgom	ery
н	Funeral		5. Social Security Number	6. S	9x 7 ☑ M 2 ☐ F		. last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Month, April	Birth Day, Ye	ar)	9. Birthpl	lace (State or Foreign
	Director		180-34-6132		E W 201	62	Yrs.					April	26,	1943	Mass	áchusetts
	and w		Usual Residence of Deceden 10a. State 10b. Cou			10c. C	ity, Town or Lo	cation							10	0d. Inside City Limits
	Aary She	ō	Maryland Mon	tgom	erv			lver	Spr	ina					,	1 ☐ Yes 2 🖾 No
	the ?	ect	10e. Street and Number					10f. Zip		9			10-	031		
	with ta or	₫	9404 Bruce	Dagi	_			101. ZIP	2090	21			Tog.	Citizen of W		try :
	eath	era	11. Marital Status	DLIA	12. Was Deced	tent Ever in I	IS 13 1	Nas Dacar			gin2 (Sn	acifu Vac or	No	14. Race	SA	on ladion
	fter d	F	1 Never Married 2 1	Married	Armed Ford	ces?	10.	f Yes, spec	ify Cuba	n, Mexican	n, Puerto	ecify Yes or Rican, etc.)	140-		, White, e	
380	urs a	by	3 ☐ Widowed 4 ☐ Divor		If Yes, Give Year or Da	1960-	-62	1 ☐ Yes :	2⊠ No	Specify:				Specify:	Whit	ce
21215-0036	72 hours after death with the Maryland naturel', or tems 23a or 28a-f show dical Examinar must be notified at	ted	15. Dece	dent's Ed	ucation		16a. Deced	dent's Usua	occupa	ition	-		16b	. Kind of Bus	iness/Ind	lustry
218	hin 7 8. 8n "n Med	ple	(Specify only high		de completed) College (1-	4or 5+1	(Give	kind of woi DO NOT us	rk done a se retired,	luring mosi)	t of work	ing		ug and		
21	d wit	Ю		-,	5+		Cl	inica	l Di	recto	r		R€	ehabil:	itati	ion
pu	e file al Hy I othe vent	3e C	17. Father's Name (First, Mid		_					_				den Sumame)	
/lai	uld b Went	2	William J.	ECK	les					A	gnes	McGo	vern			
Maryland	2 sho and le ma		19a. Informant's Name/Relati											ty or Town, S		•
≥ .	and ealth n 27		Elda S. Eckle	s/ W	ife					cive,	Sil	ver S	prin	g, MD	2090	1
ore	O T T T T		20a. Method of Disposition 1 □ Burial 2 💆 Cremati	on 3.25	Kemoval from S		Place of Dispo cemetery, cren	sition (Nan natory or o	ne of ther place	9)	May	Date 17	20c	. Location - C	ity or Tov	wn, State
Ē	Pag ment ent: ury c		`4 □Donation 5 □Othe			A1	llied Cre	matory	7		200	•	Ber	salem,	Penns	ylvania
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 le marked other than "naturel", or Items 23a or 28a-1 show any injury or other treumatic event, the Medical Examinat must be notified at once.		21. Signature of Funeral Serv	ice Licen	reser		F1	Name and and and and and and and and and and	d Addres	coll sity	ins Blvd	Funer	al H Silv	ome In er Spr	ç. ing,	MD 20901
			23a. Part1. Buter the disease shock, or heart failure.	, or comp	olications that ca	sed the dea	th. Do not ente	er the mode	e of dying	, such as	cardiac o	or respirator	y arrest,			Approximate
	Pnysician		Immediate Cause (Final disease or condition	LIST OTHY			r Fibri	115+4	ion							Interval Between Onset and Death
	/Medical		resulting in death)		u	ras a conse		ııatı	LOII						-	7
	Examiner		D		Cardi	iomyora	athv									
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter the Cause (Disease or injury	,		r as a consec										
	rcuted nd trans	Examiner	that initiated events		c											
760,	e exe ian a urial-	Ĕ	resulting in death) Last		Due to (o	ras a consec	quence of):									
876	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the buriat-transit	lical			d											
ğ V	that the death certific: ed by the attending pl detached for use as t	Physiclan/Med	IF FEMALE:	1			-									
Вох	ath c	lan/	23b. Was decedent pregnant in the past 12 months?			th 2 Feta	al death 3	Ectopic pre						23d. Date Monti		*
	the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregnai 9□Unknov	nt at time of d vn	death 5□	Other (spe	ecify)				-	NOTE		Day Year
P.O.	hat the deby detac		Part II. Other significent cond	ditions of	entribution to don	th hut not ro	ulting in the	ate at de co	Tara	. i. D. al		02a Di	d 4.a.b. a.a.a			
Vital Records,	ires tha signed d be del	by	Alcohol Abus		minouting to dea	tir but not res	sulting in the ur	idenying ca	iuse give	n in Part I.						cause of death?
0.0	w requir been si should	etec										',	1 165	2 100 3		bly 4 □Unknown
ec Sec	ne law has b	Completed											topsy	pri	or to com	sy findings available pletion of cause of
E		S											rformed:		ath?] Yes 2	2□ No
Ž	Physicien: The this certificate har all director, page	Be	25. Was case referred to med examiner?		Linea itali				Transition in			Check on				
0	Phys this c	Jo	1 ☐ Yes 2 🛣 No				ER/Outpatient		A Othe	r. 4 🗆 Nur				6 Other		
n C	tending Ph leath, tor: After th the funeral	lo	27. Manner of Death 1 X Natural 5 □ Per		28a. Date of (Month,	Day Year)	28b. Time of Injury		Bc. Injury Work			28d. Describ	e how in	jury occurred		
<u>S</u>	Attending r death, ector: After by the funer	icat		stigation ald not be	00 - 01			М		es 2□N	_		/5			
Division of	or Attendation of Att	ertification;	4 Homicide det	emined	28e. Place o building	i injury - At n j, etc. <i>(Speci</i> i	ome, farm, stre fy)	et, factory,	, office		1	City or	own, Sta	and Number ate)	or Rural i	Route Number,
	pitel burs a erel I	OI	29a. Certifier 1 ☐ XCerti	hrina Dh	reference T- shock	-1-1-1										
	Hos 24 hc Fun stely	edical	(Check only 2 Medic	cel Exem	rsicien: To the b iner: On the bas and manne	is of examina	owiedge, death ation and/or inv	occurred a estigation,	at the time in my opi	e, date and inion, deati	d place, a h occurr	and due to the ed at the tim	ne cause e, date a	(s) and mann ind place, and	er as stated due to t	ted. he cause(s)
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Med	29b. Signature and title of ceg	ifie(,	1	. 5.4466.		29c.	License	number			29d. ſ	Date signed (Month. D	ay, Year)
) A (2	ا مل	. N				269				May 1		
1	011	-	30. Name and address of pers	on who o	ompleted cause	of death (Ita-	n 23a\ /Tuna 1	Print1						ray I	ر کار	
			Matthew J						o DL	: 14∽	Dag-1	10 110	25	01	300	20022
	Sta	e	31. Date filed (Month, Day, Ye	ar)			18109 i	TIUC	e Pn	тттр	Driv	/e, #2	25,	Olney,	MD	20832
87	Registr		MAY 1	7 2	005	was s	de Ap	WELL)								

			1 - For State Registrar	State of N	laryland / Dep <i>Ce</i>		of Health a <i>of Death</i>	nd Mental H	ygiene Reg. No.	005	18379
	Physic	ian	Decedent's Name (First, Middle, La					2. Date of I	Death	Vear	3. Time of Death
	/Medi		-	Ead				Month May	13, ^{Day}		12:17a.M
	Exami	ner	4a. Facility Name (If not institution, giv 2011 Kent V		,		own, or Location of dover	Death	4c. 0	County of Death	
н	Funeral		5. Social Security Number 6. S		age (In yrs. last birthday			4 Hrs. 8 Date of F	Righ		place (Chr F
	Director		1	□M X□F	89 Yrs.		Days Hours	4 Hrs. 8. Date of E (Month, 1 1 2 / 1 6	2ay. Year) 5 / 191	5 g. Birth	place (State or Foreign intry) VA
	D >		Usual Residence of Decedent		140 00 7				,		
	shoved at	7	MD. 10b. County		Landov						10d. Inside City Limits
	the M	ect	10e. Street and Number	-	Landov	10f. Zip Co	a de		10- 0:::		Yes 2 No
	72 hours after death with the Maryland hatural, or items 23e or 28e-1 show ureal Exe. uner to vest be notified at	Funeral Director	2011 Kent Vil	lage Dr	ive	Tot. Zip Co	20785		USZ	en of What Cou A	ntry?
	death	nera	11. Marital Status	12. Was Deceder	t Ever in U.S. 13.	Was Deceden	t of Hispanic Origi	n? (Specify Yes or N		4. Race - Ameri	can Indian,
98	after or ite	F	1 Never Married 2 Married	Armed Forces 1 Tyes 2 If Yes, Give	No.			Puerto Rican, etc.)		Black, White,	etc.
5-0036	hours ural',	d by	3 Widowed 4 □ Divorced	Year or Dates	:	1 ☐ Yes 2 ☐				Specify:Bla	ck
7	in 72	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	dent's Usual C kind of work of DO NOT use i	done durina most d	of working	16b. Kind	d of Business/In	dustry
2121	filed within Hygiene. other than " ent, It e Wee	mo	Elementary/Secondary (0-12) UNKNOWN	College (1-4o	5.1		Person	nel	S.G.	Α.	
	e filed al Hygie other vent, II	BeC	17. Father's Name (First, Middle, Last) Cornelius Ja	~ l- ~				s Name (First, Middl		iumame)	
ylaı	should be filed within nd Mental Hygiene. marked other than imatic event, it e M	To	cornerrus Ja	ckson			Frai	nces Her	n		
Maryland	S 8 8 10		19a. Informant's Name/Relationship (in Delois A. Terr		19b. Maili	ng Address (S	treet and Number	or Rural Route Num	ber, City or	Town, State, Zip	Code)
	1 and Health Iem 27 other tr		20a. Method of Disposition		20b. Place of Dispo			,N.W. Wa			
Baltimore,	permit. Pages 1 ar Department of Hea Important: if item any injury or othe once.		1 XBurial 2 Cremation 3 C		Lincoln	matory or othe Mem.	r nlaco)	/18/2005		ation - City or To	
Ħ	permit. Pages Department of Important: If it any injury or o		' 4 ☐ Donation 5 ☐ Other (Specify 21. Signature o) Funeral Service Licen								ID.
ñ	permit. Departr imports any inju		Sugar S	26/1	/	John	T. Rhi	ines Fun	eral	Home	
			23a. Part1. Enter the disease, or companies shock, or heart failure. List only	olications that cause	o the ueath. Do not an	ter the mode o	f dying, such as ca	T.E. Was	n , D , C arrest,	20017	Approximate
	Physician		Immediate Cause (Final disease or condition		YOCARDIA	te in	ELECTI	200			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of):		100011	0,			
	Lammer	<u>-</u>	Suguentially list conditions.		S a consequence of	AR	TERY	D'SGAS	E		
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a		-	7	0			
Ć,	execun n and ial-tra	Exar	that initiated events resulting in death) Last	Due to (or a	s a consequence of):	1/6	LLITU	2			
68760,	icate be executed physician and s the burial-transit	edical		d. H	TRERTO	usic					
	- 00	Medi	IF FEMALE:								
Вох	death certiff e attending od for use as	ian/I	23b. Was decedent pregnant in the past 12 months?		2 Fetel death 3	Ectopic pregn	ancy		23	d. Date of delive	
0.	0 0 0	Physician/M	1 Yes 2 No 9 Unknown	4□Pregnant a 9□ Unknown	at time of death 5	Other (specif	(y)			Month	Day Year
<u>α</u>	that the ed by detac		Part II. Other significant conditions co	intributing to death	but not resulting in the u	nderlving caus	e given in Part I	23e. Did	tobacco use	contribute to th	ne cause of death?
of Vital Records,	law requires that the as been signed by th 2 should be detache	D.		v		,,	y y		Yes 2□		1.0
000	aw requir as been si 2 should	ompleted						24a. Was	s an	24h Were auto	psy findings available
æ	The la ate ha page 2	шо						auto	psy ormed?	prior to cor death?	npletion of cause of
ita	sian: artifica ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of	1 ☐ Yes Death (Check only	2 No one)	1 🗆 Yes	2 No
<u>></u>	Physician: this certific al director,	To	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 ER/Outpatien	t 3 DOA	Othor	ng Home 5 Res		Other (Specify	()
		on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injui	ary Year) 28b. Time of Injury		Injury at Work?	28d. Describe	how injury o	occurred	
Division		icat	2 Accident investigation 3 Suicide 6 Could not be	290 Place of In	ium. At home form		1 ☐ Yes 2 ☐ No		(0)		
_	i or Atten after deat Director: I in by the	Certification:	4 Homicide determined	building, e	jury - At home, farm, str tc. <i>(Specify)</i>	еет, тастогу, оп	lice	City or To	wn, State)	Number or Rura.	l Route Number,
	To the Hospital or Al within 24 hours after or To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying Phy	sician: To the best	of my knowledge, death	occurred at the	ne time, date and p	place, and due to the	cause(s) an	d manner as st	ated
	hs Ho in 24 he Fu pletel	edical	(Check only one) 2 Medical Exam	ner: On the basis of and manner st	or examination and/or inv	estigation, in r	ny opinion, death	occurred at the time,	date and pla	ace, and due to	the cause(s)
	To the I within 2. To the I complete	Σ	29b. Signature and title of certifier			29c. Lic	cense number		29d. Date s	igned (Month, L	Day, Year)
^				//		1	7311		5	605	
		1	30. Name and address of person who c	4. 41.8			1 0				1
	Sta	te.	31. Date filed (Month, Day, Year)	King,	MD 10	10 + C	ung 5	t, NW 1	V420	DO MA	ish oc
	Registra		MAY 1 8 2005		4 1.					and (0010.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Physician 2005 12 09:00 A.M. ANNA BEULAH FORT May /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Adelphi Prince George's Heartland Nursing Care If Under 1 Year 8. Date of Birth (Month, Dey, Yeer)
July 7, 1923 5. Social Security Number 7. Age (In yrs. lest birthdey) If Under 24 Hrs. Birthplece (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 X F Yrs. Director 578-22-6203 Washington, DC Usuel Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Depertment of Heelth and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, tra Medical Examiner must be notified at PAGE. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Director MD Prince George's Hyattsville 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? U.S.A. Funeral 2310 Ritterhouse Street 20782 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2X No 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: ģ 3 Widowed 4 Divorced White Be Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Beulah Williamson Fort John Edward Fort 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 2310 Ritterhouse Street, Hyattsville, Maryland 20782 Richard Fort, Nephew 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from Stete 4 ☐ Donetion \5 ☐ Other (Specify) / 5/14/05 Alexandria, Virginia Metropolitan Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityGasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, Maryland Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Due to (or es a consequence of): Advanced Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es a consequence of) resulting in death) Last use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No ģ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an autopsy performed? 1 ☐ Yes 2 ☐ 1√0 TLYUS ZLINO certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 □ Residence 6 □ Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. edicai 29a. Certifier (Check only 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 2005 4566 30. Neme end address of person who completed cause of death (Item 23e) (Type, Print) 1220 A Ecent toppa Road Seek 230, Toce Son MD 21286

DHMH 16 Rev 6/95

State

Registrar

Sucilla Bhogavili

MAY 1 8 2005

31. Dete filed (Month, Day, Year)

			For State Registrar	30 1				d / Depa		t of H	ealth a		•		ne . No.	005	18381	
			Decedent's Name (First, Midd	le, Last)									2. Date of				3. Time of Death	_
	Physici		JAMES					FARM	ATD.			0	Month MAY	7	Day	2005	N/	4
	/Medic Examin		4a. Facility Name (If not institution	n, give s	street and nu	mber)		PAIN		Town, or	Location of		MAI		4c. (County of De	21:58 P	_
	Examin	CI	3600 SETH COU	-					SPI	RING	DALE				P!	RTNCE	GEORGE'S	
	Funeral		5. Social Security Number	6. Sex	(7. Age (In yrs. I	last birthday)	If Under	1 Year	If Under		8. Date of (Month,	Birth			rthplace (State or Foreig	n
	Director		240-72-6092	1 23	M 2□F	57		Yrs.	Months	Days	Hours	Min.	Janua	ry :	5 1	948 No	orth Carolin	ıa
	9		Usual Residence of Decedent											-			T	
	how	_	10a. State 10b. County			1	Oc. City	y, Town or Lo	ocation								10d. Inside City Limits	
	Ba-f s	ct	MD Princ	e Ge	eorge'	s	Sp	oringd	ale								1X Yes 2 □ No	,
	or 28	Director	10e. Street and Number						10f. Zip	Code				10g	. Citiz	en of What C	Country?	
	23a	rai	3600 SETH COUR	Г						774					S.A			
	r deg	Funerai	11. Marital Status		12. Was Dec Armed F	orces?	er in U.	S. 13.	Was Deced	tent of Hi	ispanic Ori n, Mexicar	gin? (Spo 1, Puerto	ecify Yes or Rican, etc.)	No-	1.	 Race - Am Black, Wh 	erican Indian, ite, etc.	
36	or it	by Fi	1 Never Married 2 Mar		1 ☐ Yes If Yes, G	ive			1 ☐ Yes	2█ No	Specify:				١,	Specify: p	lack	
8	i within 72 hours after death with the Maryland liene. I than "natural", or items 23a or 28a-f show the Medical Examinar must be motified a		3 Widowed 4 Divorce		Year or E	Dates:		40+ B	dent's Usua					140	L (6:-			
5	"nat	jete	15. Deceder (Specify only highs	st grade	cation e completed)			(Give	kind of wo	rk done d se retired	du <i>ring m</i> os	t of work	ing	16	D. KIN	d of Busines	sylindustry	
12	within ene. than "	Completed	Elementary/Secondary (0-12)		College (1-4or 5+))perat		,		Private					
d 2	be filed vital Hygie of other leader.	o C	17. Father's Name (First, Middle	Last)				Dab c	Portu		18. Mothe	r's Name	First, Midd					_
Maryland 21215-0036	Q 22 D .	To B	James Oscar Fa	rmei	-						Oliv	ia B	arnes					
7	2 should and Ments to market	F	19a. Informant's Name/Relation					19b. Maili	ng Address	(Street a				nber, C	ity or	Town, State,	Zip Code)	
S	0 0 0		Geraldine Farm	er/1	Wife			3600	Seth	Cou	rt St	ring	Dale	. M.	arv	land 2	20774	
ē,	item 27	Ì	20a. Method of Disposition				20b. P	lace of Dispo emetery, cre	and the second second			- 1	Date				r Town, State	_
Baltimore,			1 ⊠ Burial 2 ☐ Cremation 4 ☐ Donation ☐ ☐ Other (lemoval from	State	İ	mony C				5/14/	/05	La	ndc	wor Me	aryland	
=	그 문문을 .		21. Signal of Date at 3	License	90	\	HGII	-	2. Name an			2.						
B	permi Depa impo any i			17	1)		7	474 T	ando	ver I						al Home ad 20785	
			23a. Part1. Enter the disease, of	r compli	ications that	caused th	ne death									lar y Lai	Approximate Interval Between	
	Physician		shock, or heart failure. Lis Immediate Cause (Final	t only or		tast:		. Col	on Ca								Onset and Death	
7	/Medical		disease or condition resulting in death)	• a	a			uence of):	on ca	псет							10 months	_
	Examiner			1		,												
Ь,		Jer	Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury	,	Due to	(urasa)	núnsedt	uence of):										_
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	١,														
oʻ	te be executed ysician and te buriai-transit	EX	resulting in death) Last		Due to	(or as a	consequ	uence of):									I	
760,	w = w	cai		C.	d												1	
99	ieath certificat attending phy I for use as th	Jed	IE EEN E	1											1			_
Вох	death certifica e attending ph id for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant	2	3c. If yes, ou	itcome of birth 2			DEctopic pa	egnancy					23	3d. Date of de	,	
	0 0 0	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		4∐Preg 9☐ Unkr	nant at tir	me of de		Other (sp							Month	Day Year	
P.0	at the de by the a	Physician/Med	9 Unknown															
	The law requires that the ste has been signed by th bage 2 should be detache	by	Part II. Other significant condit	ons cor	ntributing to d	death but	not resu	ulting in the u	inderlying c	ause give	en in Part I						to the cause of death?	
Records,	w require been si should I	ted											''	Yes	2	JNO 3 F	Probably 4 LUnknown	_
e C	lawr as be 2 sh	pje											24a. W	topsy		prior to	autopsy findings available completion of cause of	
E.		Completed											1 ☐ Yes	rforme s 2		death? 1 ☐ Ye	s 2 No	
Vital	Physician: The this certificate ral director, page	Be (25. Was case referred to medical examiner?										n (Check on					
of V	hysic this co	2	1 ☐ Yes 2 🛣 No	1		Inpatient		ER/Outpatie								Other (Sp	ecify)	
		on:	27. Manner of Death 1 Natural 5 Pend:	ing	28a. Date (Mor	of Injury oth, Day	Year)	28b. Time o		8c. Injun Worl			28d. Describ	e how	injury	occurred		
sio	Attending or death.	cat	2 Accident invest	tigation I not be			-		M		Yes 2 🗌	-	not tonation	104			Description of the section	_
Division	l or Attendate after death	Certification;		mined	28e. Plac build	e of Injury ling, etc.	y - At ho (Specify	ome, farm, st y)	reet, factory	/, office			City or			Number or F	Ru <i>ral Route Number</i> ,	
	urs a urs a sraf D		00 0 dV 0 dV	Ph.	alalan Tout										(-)			
	Hospital 24 hours a Funeral I	lica	29a. Certifier 1 X Certify (Check only 2 Medica	i Exemi	sician: To the	basis of e	xamina	tion and/or in	in occurred ivestigation	, in my of	pinion, dea	ith occuri	ed at the tim	ie, date	and p	place, and du	is stated. ie to the cause(s)	
	the the the	Medical	29b. Signature and title of certifi	er	and mai		,d.		290	. License	e number			29d	. Date	signed (Mor	nth, Day, Year)	
	To To		1 06		_	M				D506						3/200		
^	(in)		20 Name and address of	-	ampleted as	2000	ath /ita-	n 23a\ /T	Drint\						-	7 200	٠_٠	
K	(10)		30. Name and address of person							650	# 19	/ Ra	wie W	larv	12*	nd 207	16	
	Sta	ite	Gurdeep Chha 31. Date filed (Month, Day, Year	bra ')						апе	T 1.Z	4 100	итс, Г	ur y	 G1	207		
	Regist		MAY 1 8 2	2005	Bla	tu	K.	Loca	Le sur									

			1 - For State RegistraMEND#10aboperFH5/	tate of Marylar	_	tment of He		Mental Hy	211115	18382
			Decedent's Name (First, Middle, Last)	1//US,HW,MDC	00111	neate of L	,catri	2. Date of De	Reg. No.	3. Time of Death
	Physici		Stanley,		G	lassma	-n	Month	Day Yea	10- 14
	/Medic Examir		4a. Facility Name (If not institution, give street	at and number)		lb. City, Town, or I	Location of Deatl	may	4c. County of De	0 100
	LXXIIII	iei	The Topic Han	LUNS HOSE	stin/	R. 14:	more	1. Lu		
	Funeral		5. Social Security Number 6. Sex	7. Age (Invyrs.		If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th 9. B	irthplace (State or Foreign
п	Director		577-42-3461 X ^M	^{2□ F} 82	Yrs.	Months Days	Hours Min.	Month, Da		Sountry) shington, DC
	pu >		Usual Residence of Decedent 10a. State 10b. County	10- 0	T					71 10
	aho	7			ty, Town or Loca					10d. Inside City Limits
	the M	Director	D.C. None 10e. Street and Number	Was	hington					Yes 2□No
	a or			27 77		10f. Zip Code			10g. Citizen of What (Country?
	eath	Funeral	2801 New Mexico Aven	.ue N.W. Was Decedent Ever in U	S 12 W	20007	nania Osiais 2 /S		U.S.A.	nerican Indian,
	fter d	Fun		Armed Forces?	If Y	s Decedent of His es, specify Cuban	, Mexican, Puert	o Rican, etc.)	Black, Wi	
98	urs a	by		If Yes, Give Year or Dates:	1 🗆	Yes 2√√ No	Specify:		Specify: W	hite
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f ahow dical Examinat must be rediffed at	Completed	15. Decedent's Education	on	16a. Deceder	it's Usual Occupat	tion		16b. Kind of Busines	s/Industry
7	thin 7	ple	(Specify only highest grade co	College (1-4or 5+)	life. DC	nd of work done du NOT use retired)	iring most of wor	King		
21	ed wi	Con		4	Genera	1 Contra	ctor		Construct	ion
nd	be fill d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Maiden Sumame)	
₹	ould Men Marke	2	Herbert Glassman				Dorothy			
Maryland	l 2 sh and l srr raurr		19a. Informant's Name/Relationship (Type,	•					er, City or Town, State,	
d)	ss 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "naturat", or items 23a or 28a-1 ahow other traumatic event, the Medical Examiner must be collined at		Betty Glassman / Spo 20a. Method of Disposition		2801 N	ew Mexico	o Ave. N	.W. Was	hington, D	
Baltimore,	W = OF		1 XBurial 2 ☐ Cremation 3 ☐ Remo	Wal IIOIII State		on (Name of lory or other place)	May	15.	20c. Location - City of	or Town, State
를	it. Pag intment injury	í	' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	Gar		Remembra		05	Clarksburg	, Maryland
Ba	permi Depa Impo any ir		21. Signature of Fulleral Service Acerts 9						wler's Son	
	a a		23a. Part1. Enter the dispase, or complication	ons that caused the deat						D.C. 20016 Approximate
	Discost at an		shock, or heart failure. List only one commediate Cause (Final	ause on each line.				an respiratory a	1000,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseq	Electri	cal Ac-	tivity			4 hours
	Examiner			H cos cole	uence on.	. /22				Shours
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):	OCK				3110013
	cuted nd ransil	Examiner	Cause (Disease or injury that initiated events	Hostridium	diffic	ile coli	tis			10 days
ó	ate be executed hysician and the burial-transit	Ë	resulting in death) Last	Due to (or as a conseq	uence of):					
8760,	zate be executed bysician and the burial-transit	Physician/Medical	d							
9	death certific e attending p id for use as i	Med	IF FEMALE:							
Вох	ath c	ian/	in the past 12 months?	f yes, outcome of pregna □Live birth 2 □ Feta	Ideath 3⊟Eo	topic pregnancy			23d. Date of de Month	eliv ery Day Year
o.		yslo		4□Pregnant at time of d 9□Unknown	eath 5∐C	ther (specify)				
<u>α</u>	The law requires that the death certific lie has been signed by the attending p page 2 should be detached for use as	H-	Part II. Other significant conditions contrib	uting to death but not res	ulting in the unde	orlying cause given	in Part I.	23e. Did to	obacco use contribute	to the cause of death?
ds,	uires sign	d by						1 🗆 1	′es 2ÃNo 3∏F	Probably 4 Unknown
00	w rec	lete						24a. Was	an 24h Were s	autopsy findings available
of Vital Record	Physiclan: The lav this certificate has ral director, page 2	Completed						autop	rmed? prior to death?	completion of cause of
ta	iclan: Th certificate rector, pag	O	25. Was case referred to medical				26 Place of Dea	1 ⊠ Yes th (Check only o		s 2 No
\geq	Physiclan: r this certificatal director,	ToB	examiner? 1 ☐ Yes 2' 🔁 No Hosp	ital:	ER/Outpatient	Other			lence 6 □Other (Sp	ecify)
	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	8a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work?			low injury occurred	
Ö	Attending r death. ector: Atter	atle	2 ☐ Accident investigation		,,		es 2 □No			
Division	I or Atten after deat Director: I in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined 2	Be. Place of Injury - At he building, etc. (Specify	ome, fam, street	, factory, office		28f. Location (S City or Tox	Street and Number or F in, State)	Rural Route Number,
Ω	urs af	Ce								
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 Certifying Physicia 2 Medical Examiner:	On the basis of examinal	wledge, death or tion and/or inves	curred at the time tigation, in my opir	, date and place, nion, death occur	and due to the ored at the time,	cause(s) and manner a date and place, and du	is stated. le to the cause(s)
	o the ithin o o the	Mec	29b. Signature and title of certifier	and manner stated.	·	29c. License	number		29d. Date signed (Mor	oth Day Year)
	4		Bullet	Det MD		Res -			May 12	
	1		30. Name and address of person who comple	eted cause of death (Item	23a) (Type Pri				3.7	
			BrendaMacknight			,	+ Bas	2timor	e, Mn z	1287-9100
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ture	l a			11.11	0 . 1100
	Registra	ar	MAY 1 7 2005	HARVE D	GOBA					

		Please I	State of Maryland / Dep		•	_	
		1 - Stete Registrer		rtificate of Death		, No. 2 A D 5	10000
Physi	cian	1. Decedent's Name (First, Middle, Last)	Cibbe		2. Date of Death Month	Day Year	3. Time of Death
/Med		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Death		2 205 4c. County of Death	2120 ™
Exam	iner	THE MEMORIA	. 1	EASTON		TALBO	7
Funera	1	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday		8. Date of Birth (Month, Day, Y		place (State or Foreign
Directo		240-44-1262	M 2 F 69 Yrs.	Months Days Hours Min.	Sept. 28	1935 NOK	th Carolina
land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation	/	1	l0d. Inside City Limits
Many -f she	tor	MD Dorch	ster Ca	nbnidae			1 ☐Yes 2 ☐ No
or 28s	Director	10e. Street and Number		10f. Zip Code	100	g. Citizen of What Cour	ntry?
death with the Maryland ms 23e or 28a-f show	ralD	709 Rigby	Avenue	2/6/3		USA	
	Funeral		Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (St If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
hours after death with the Marylan hours after death with the Marylan turel', or Items 23e or 28a-f show at Examire or must be notified at	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1	1 ☐ Yes 2 ☑ No Specify:		Specify:	- 4
72 hours "naturel",	ted	15. Decedent's Educ	cation 16a. Dece	edent's Usual Occupation	ling 16	6b. Kind of Business/In	dustry
	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	ving :	2	C ,
led within lygiene.		17. Father's Name (First, Middle, Last)	Mac	chine Operat	TO R Middle, Ma	endering	tactory
and d be fi antal H sed of	Be		Ciloloc	18. Mother's Nam			/
aryic should nd Mer marke	2	19a. Informant's Name/Relationship (Ty)	pe, Print) 19b. Mail	ing Address (Street and Number or Ru.	ral Route Number, C		Code)
MG 2 Inthe a 27 Is		Oceanious	Gibbs 709	-Righy Ave. (ambrid	se Maryla	nd 21613
ges 1 a t of Heg If item or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	20b. Place of Disp cemetery, cre	osition (Name of ematory or other place)	Date 20	c. Location - City or To	wn, State
Pa Then Then Then Then Then Then Then Then		`4 □ Donation 5 □ Other (Specify)	Cordtow			ambridge	, maryland
Balti Permit. Departm Importa eny inju	900	21. Signature of Funeral Service License	2/ 2/	22. Name and Address of Facility HENRY FULL WERAL SILVER TO WASHINGTON	Home, C.	4	0 0 1/ 13
		23a, Part 1 Enter the disease, or compli	cations that caused the death. Do not en	nter the mode of dving, such a cardiac	or respiratory arres	Abridge, M	Approximate
		Immediate Cause (Final	e cause on each line.	mı i			Interval Between Onset and Death
Pnysicia /Medica	_	disease or condition resulting in death)	Due to (or as a consequence of):	Mye Ioma			
Examine	r	Sequentially list conditions.	<u> </u>				
pe tis	Iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a consequence of):				
ou, be executed ician and buriat-transi	Examine	that initiated events resulting in death) Last	Due to (or as a consequence of):				
f 6U, te be executed ysician and be burial-transit	calE		l				
tifica g ph as th							
SOX th cer tendin	an/N	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 3	□Ectopic pregnancy		23d. Date of delive Month	
	Physiclan/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 5 9☐Unknown	Other (specify)		Month	Day Year
a by	/ Ph	Part II. Other significent conditions con	tributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
8 6 6 G	d by	Pneumonia			1 ☐ Yes	2 No 3 Prob	ably 4 Unknown
20 0	Completed	Hypercal			24a. Was an	24b. Were auto	psy findings available
→ 0 - 3	mo	Renal 1	he II was		autopsy performe	death?	mpletion of cause of 2□ No
VITAL P ilcien: Th certificate rector, pag	Be (25. Was case referred to medical	nsul, rerendy		th (Check only one)		
OT VITA Physicien: r this certific ral director,	7	TE Yes ZY NO	ospital: 1 Inpatient 2 ER/Outpatie		ome 5 Residence	ce 6 Other (Specify	y)
tending Physical death.	tion	27. Manner of Death Salar Sal	(Month, Day Year) Injury	of 28c. Injury at Work? M 1 □ Yes 2 □ No	200. Describe now	injury occurred	
LIVISION OF VITA stor Attending Physicien: s after death. I Director: After this certific d in by the funeral director,	ifica	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s	treet, factory, office	28f. Location (Stre	et and Number or Rura	l Route Number,
5 Sir fee	Certification:	4 U Homicide	building, etc. (Specify)		City or Town,	State)	
To the Hospitet within 24 hours a To the Funerel I completely filled	Medical	29a. Certifier 1 Certifying Phys (Check only one)	sicien: To the best of my knowledge, dea ner: On the basis of examination and/or in and manner stated.	ith occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the causered at the time, date	se(s) and manner as si a and place, and due to	ated. the cause(s)
To the within 2 To the	Mec	29b. Signature and title of certifier	and manner stated.	29c. License number	29d	. Date signed (Month,	Day, Year)
⊢ <i>s</i> ⊢ ŏ		> you ha	11 Shield in	D47232		05/12/	2005
		30. Name and address of per on who co		, Print)		~ 131	400
			M.D., 509 Idlewild	Ave., Easton, MD	21601		
S Regis	State	31. Date filed (Month, Pay Year) 7	32. Registrar's Signature	forthe .			

DHMH 17 Rev 1/2001

Gi88s, Otis

DHMH 17 Rev 1/2001

8279

Robert

reen,

Kevin Alonzo Hall 05-RJ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

03:	280		1 - State AMEDINATION TO BE	State of Marylar					nd M	ental Hy	giene	2005	10005
			1 - Stete Registra AMEND#7p=rFH5/. 1. Decedent's Name (First, Middle, Las		Ce	rtificate	of D	eath		2. Date of De	Reg. No	. 000	3. Time of Death
	Physici /Medi		Kevin A. Hal	_						Month May 11	Da	y Year 005	6:00 p. M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, To	own, or L	ocation of	Death	riciy 11	7	. County of Death	
			Prince George's He			Cheve		If Under 2	A Hro	2. 0-1-10	Pr	ince Ge	
	Funeral Director	П		7. Age (In yrs.	$2423_{\rm Yrs.}$	Months (Hours	Min.	8. Date of Bir Month, Da Sept.	5.1	981 Was	nplace (State or Foreign untry) hington, DC
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation							10d. Inside City Limits
	Maryl	to	MD Prince G		emple	Hills							1 ★Yes 2 No
	or 286	Funeral Director	10e. Street and Number			10f. Zip C					_	tizen of What Cou	•
	eath w	erai	4311 23rd Park		6 12	Was Danadar	207		in? (Can	aifu Van as Na		ted Stat	
9	after d or Item	Fun	1★Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No		If Yes, specify	1.		Puerto i	cify Yes or No Rican, etc.)		Black, White	
003	72 hours after death with the Maryland natural', or Items 23e or 28e-f ahow dical Evantrative for molified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	,			Specify:				Specify: Bla	
215	c * 8	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation de completed) College (1-4or 5+)	(Give	dent's Usual (kind of work of DO NOT use	Jecupati done dui retired)	on ring most	of workir	ıg	16b. K	ind of Business/I	ndustry
21	filed within Hygiene. other than "		12th		Uner	nployed						employed	
land	should be filed within of Mental Hygiene. marked other than imatic avent, Ira M	To Be	17. Father's Name (First, Middle, Last) Perry A. Lewis				1			(First, Middle a.A. Ha		Sumame)	
Baltimore, Maryland 21215-0036	S S S	-	19a. Informant's Name/Relationship (7		19b. Mailir	ng Address (S	Street and	d Number	or Rura	Route Numb	er, City o	or Town, State, Zi	p Code)
e, R	1 and 2 Health tem 27		Patricia A. Hall/ 20a. Method of Disposition					St. 3		o wasn		on DC 20	
mor	Pages nent of I		1 ☐ Burial 2 🗷 Cremation 3 ☐: 1 ☐ Donation 5 ☐ Other (Specify		Place of Dispo cemetery, crer verdale			. M:		1,2005		erdale,	
3alti	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licens			. Name and		11 10		3821	140	LSTAU	
ш	70 % # g		23a. Part 1. Enter the disease, or comp	ligations that caused the deat	h. Do not out	HUS/1	11	50,5/4	er	Funer:		bne	DC 2001
b	Pnysician.		Immediate Cause (Final	ne cause on each line.	il ala	Gunsia			59	төзрпатогу а	iiesi,		Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	a	uence of):	LAGION	ن (د)	UUTLI					
	Lxammer	-	Sequentially list conditions,	b. — Dira to for as a consect	uance offi-								
	cuted id ansit	Examine	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	c									
8760,	be executed sician and burial-transit	ai Ex	resulting in death) Last	Due to (or as a conseq	uence of):								
687	ate hys	edicai		d									
Вох	eath certific attending p for use as f	an/M	ZOD. Was decadelli pragnant	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta		Ectopic pregi	nancy					23d. Date of deliv	*
0.		Physician/M	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \) 9 \(\subseteq \text{Unknown} \)	4□Pregnant at time of d 9□ Unknown		Other (speci						Month	Day Year
<u>α</u>	requires that the een signed by th hould be detache	by Ph	Part II. Other significant conditions co	ntributing to death but not res	ulting in the ur	nderlying caus	se given	in Part I.		23e. Did t	obacco u	ise contribute to t	the cause of death?
Vital Records,	w require been sig should b									1 🗆 '	Yes 2	No 3□Prol	bably 4 Unknown
Rec	has b	ompieted							_	24a. Was autop		24b. Were auto prior to co death?	opsy findings available empletion of cause of
ital		e C	25. Was case referred to medical				2	6. Place	of Death	1 Yes Check onl	2 No	1 Yes	2□ No
of V	Physicien: this certific ral director,	To B	126 162 5 140	Hospital: 1 🛭 Inpatient 2 🗆	ER/Outpatien		Other:	4 Nurs				6 □Other (Specia	fy)
	dlng h. After funei	tion	27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury factorith, Day Year)	28b. Time of Injury	RI	injury at Work?			8d. Describe i	now injur	y occurred Séli	bject was
Division	I or Attano after death Director: I in by the	ertification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, stre				_	Bf. Location (S	Street an	d Number or Rura	al Route Number
۵	pital or Al	O		resid	Jence P	utic				23 34	LTICUR	d, mo	GI HULK W.
	4 th	edical	29a. Certifier 1 Certifying Phy (Check only one)	sicien: To the best of my kno iner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at t restigation, in	the time, my opin	date and ion, death	place, a	nd due to the d at the time,	cause(s) date and	and manner as s place, and due to	tated. o the cause(s)
	To tha within 2 Yo the Complet	Me	29b. Signature and title of certifier			29c. L	icense n	umber ME				e signed (Month,	
,	2	1	+amen Down	half, MI)							ınay	13, 200)
			30. Name and address of person who continued E. Sand	ompleted cause of death (Item	1 23a) (Type, 1	111 i	Penn	Str	eet	Balti	more	, Maryla	nd 21201
4	Sta		31. Date filed (Month, Day, Year) MAY 1 7 20	32 Registrar's Signa	ture day	de			14	1-1			
	Registr	ar	MINI T (20	THE STATE OF	19								

				State of Ma	ryland / Dep		Health and I	Mental Hygi	9	18386
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Fred Julius Hamb	urger				2. Date of Death		3. Time of Death 12:15P.M
	Examir		4a. Facility Name (If not institution, give st 7909 Ivymount Terra	reet and number)		4b. City, Town, Potoma	or Location of Death	1	4c. County of Death Montgomer	
	Funeral Director	П		M 2□F	(In yrs. last birthday 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Aug. 8,	9. Birth 924 Gerr	place (State or Foreign intry) Many
	Aaryland Fehow ed at	ō	Usual Residence of Decedent 10a. State 10b. County Maryland Montgomer		10c. City, Town or L Potomac	ocation				10d. Inside City Limits 1 ☐ Yes 2 → No
	with the N 3a or 28a-	Direct	10e. Street and Number 7909 Ivymount Terra	ace		10f. Zip Code	20854	10	g. Citizen of What Cou United Sta	intry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show any Injury or other traumatic event. If a Modical Exactines: ust be notified at once.	Completed by Funeral Director	11. Marital Status 1: 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ev Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub	dispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- Pican, etc.)	14. Race - Ameri Black, White, Specify: W	can Indian, , etc. nite
21215-0036	within 72 hou ene. then "netura re Medical E	ompieted	15. Decedent's Educe (Specify only highest grade Elementary/Secondary (0-12)	ation	16a. Dece		pation during most of won d)	king	6b. Kind of Business/Ir	
land 2	ild be filed fental Hygi rked other ilc event.	To Be Co	17. Father's Name (First, Middle, Last) Ludwig	Hamburge	er		18. Mother's Nam Margaret	ne (First, Middle, Mi	aiden Sumame) Toepli	itz
, Maryland	and 2 shou aith and M 27 Is man		19a. Informant's Name/Relationship (Typ Irene Hamburger –da	aughter	19b. Mail	ing Address (Street Jackson S	and Number or Ru treet Bro	ral Route Number, oklyn, Ne	City or Town, State, Zip SW York 112	o Code) 211
Baltimore,	Pages 1 and of He int: If Item		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	moval from State	20b. Place of Disp cometery, cre Judean Me	osition (Name of matory of other pla EMORIAL G	ardens 5/	Date 20 16/2005 (oc. Location - City or To Olney, Mary	own, State yland
Balti	permit. Departri Importa any Inju		21. Signature of Funeral Service Licensee	Butwa	ald E	Solialad Vore 400 Powde	Borgward er Mill R	t Funeral oad Belts	Home, PA ville, Mar	yland20705
	Priysician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	-		ter the mode of dyi				Approximate Interval Between Onset and Death
	/Medical Examiner	- e	resulting in death) Sequentially list conditions, b.	Type I I	consequence of): Diabetes M	Mellitus				
,092	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	cai Examiner	Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):					
			d.	c. If yes, outcome of	nragnanov					
.O. Box	The law requires that the death certifica to has been signed by the attending phoage 2 should be detached for use as the	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 4 Pregnant at tir 9 Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	<u> </u>		23d. Date of delive Month	ery Day Year
rds, P	quires that on signed to uld be det		Part II. Other significant conditions contr	ributing to death but	not resulting in the u	inderlying cause giv	en in Part I.		cco use contribute to the	
al Records,	The lay	Completed						24a. Was an autopsy performe	prior to condeath?	psy findings available mpletion of cause of 2 No
† VII	Phyaician: The ta this certificate has ral director, page 2	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 lnpatient	2 ER/Outpatie	nt 3 DOA Oth		h Check onl one	ce 6 □Other (Specifi	y)
Division of Vital	<u>a</u> = <u>a</u>	ertification;	27. Manner of Death 1 🛣 Natural 5 🗍 Pending 2 🗋 Accident investigation	28a. Date of Injury (Month, Day Y	28b. Time o (ear) Injury	Wor	y at	28d. Describe how		
DIVIS	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	O	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	- At home, farm, st (Specify)	reet, factory, office		28f. Location (Stre City or Town,	et and Number or Rura State)	l Route Number,
	To the Hospital within 24 hours a To the Funeral C completely filled it	edical	29a. Certifier (Check only one) 1	cian: To the best of ear: On the basis of ear and manner state	camination and/or in	h occurred at the tirvestigation, in my c	ne, date and place, pinion, death occur	and due to the cau red at the time, date	se(s) and manner as si a and place, and due to	ated. the cause(s)
,	To with	₹ (29b. Signature and the of certifier	au		29c. Licens D356			Date signed (Month, lay 16, 200	
ı	- 0		30. Name and address of person who com Karl Salman, M.D. 8	pleted cause of dea 3830 Camer	th (Item 23a) (Type, on Street	Print) Silver S	Spring, M	aryland 2	0910	
	Sta Registra		31. Date filed (Month, Day, Year) MAY 1 7 2005	= 32 Registrar's						

			1 - For Stete Registrar	State of M	larylar			t of H	ealth a	and M			2005	18387
	Physici	ian	1. Decedent's Name (First, Middle	11	n						2. Date of Dea Month	Day		3 Time of Death
	/Medi Examir		4a. Facility Name (If not institution,	give street and number			4b. City,	Town, or	Location of	of Death	MAY	4c.	County of Death	e-AM
			Shady Grove Ad					kvi1					Montgor	mery
П	Funeral Director		5. Social Security Number 201–22–2934	6. Sex 7. A 1 ☐ M 2 💢 F	.ge (<i>In yr</i> s. 76	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Nov • 2	h /, Year) 2 1 0	9. Birth	place (State or Foreign intry)
	D		Usual Residence of Decedent								NOV. Z	5,19	28 PA	
	Maryla f show	٥	10a. State 10b. County		10c. Cr	ty, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 🗓 No
	n 18a-	Director	MD Montgo	omery			Rockv 10f. Zip					10g. Citi	izen of What Cou	
	ath wit	raiD	14431 Traville	e Garden Ci	rc1e	#404 D	2	0850				U	nited St	tates
980	be filed within 72 hours after death with the Maryland nat Hygiene ad other than "natural", or Items 23a or 28e-f show event, the Medical Event writinal by notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☒ Divorced	12. Was Deceden Armed Forces ad 1 Tyes 2 Tild Yes, Give Year or Dates	? (No		Was Deced If Yes, spec 1 ☐ Yes 2		spanic Ori n, Mexicar Specify:		cify Yes or No- Rican, etc.)		14. Race - Amer Black, White Specify:	
21215-0036	n 72 ho "natur edical	Completed	15. Decedent' (Specify only highest			(Give	dent's Usua kind of wor DO NOT us	k done d	urina mos.	t of workin	ig	16b. Ki	nd of Business/Ir	ndustry
212	d within glene. Ir than "	dwo	Elementary/Secondary (0-12)	College (1-4or	5+)	Admin				istan	t	Ae	rospace	
nd	be filed tal Hygie d other	Be	17. Father's Name (First, Middle, L	•							(First, Middle,	Maiden		
Maryland	2 should be and Mental Is marked o	Jo.	John James McCa			40h 44-18		(0)			gnes Le			
	nd 2 sl ilth an 27 Is r r traur		19a. Informant's Name/Relationsh Mary F. Mitchel										r Town, State, Zi, ng , MD 2	
Baltimore,	of Head		20a. Method of Disposition 1 ∑Burial 2 ☐ Cremation		20b. F	Place of Dispo			.	Da	ate		cation - City or T	
ţ	t. Pag rtment rtent: I		' 4 □ Donation 5 □ Other (Sp	ecify)	" .	e Mari	a Cem	eter	y	4ay 1 2005			Dudley,	PA
Bal	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e		21. Signature of Euneral Service C	Eur)		D	eer P	ark	Drive	e, Ga	ithersh	ourg	Home, 1	.0 East 377
ı	Physician /Medical		23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	nly one cause on each	uffli	Œu	-				respiratory arr		ING	Approximate Interval Between Onset and Death MONHS
п	Examiner		Sequentially list conditions,	b										
	rted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or a	з а сопвэц	uence of).								
oʻ	cate be executed obysicien and the burial-transit	Exai	that initiated events resulting in death) Last	c Due to (or a	s a conseq	uence of):							-	
8760,	cate be ohysici the bu	dicai		d										
P.O. Box 6	death certifii e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	ideath 3 □	Ectopic pre Other (spe					2	23d. Date of delive Month	ery Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant condition	s contributing to death	but not res	ulting in the ur	nderlying ca	iuse give	n in Part I.		23e. Did tol			he cause of death?
Vital Records,	The ete h	Completed									24a. Was a autops perform	sy med?	24b. Were auto prior to co death? 1 \sum Yes	psy findings available mpletion of cause of
Vit	Attanding Physician: Ir death. sector: After this certific by the funeral director.	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No	Hospital: 1 X Inpat	ent 2 🗆	ER/Outpatien	t 3□ DO.	Other			(Check only on		☐Other (Specif	£.1
n of		T :uc	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inj (Month, Da		28b. Time of Injury		Bc. Injury Work			Bd. Describe ho			y)
Division	or Attanding after death. Diractor: After in by the funer	catio	2 Accident investiga 3 Suicide 6 Could no	tion			M	1 🗆 Y	es 2□N	-				
ρi	at or A safter I Dirac d in by	Certification:	4 ☐ Homicide determin	28e. Place of In building, e	tc. (Specify	ome, tarm, stre y)	eet, factory,	office		28	City or Town	reet and n, State)	d Number or Rura	al Route Number,
	To the Hospital or Atlanding Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	edicai	29a. Certifier (Check only one) Check only one)	Physician: To the best xaminer: On the basis of and manner s	of examina	wledge, death tion and/or inv	occurred a restigation,	it the time in my opi	e, date and nion, deat	d place, ar h occurre	nd due to the ca	ause(s) ate and	and manner as s place, and due to	tated. o the cause(s)
}	To T com	Σ	29b Signature and title of certifier	Q nue	11.		29c.	License	number		2	9d. Date	signed (Month,	Day, Year)
	8		30 Name and address of person w	ho completed cause of	death (Item	1 23a) (Type	Print)	, 0	+ 20.	7	0	NA	1 15, 20	005
	- C=		JOMES D. B	am 4000S	970	7 MED	KA (TONT	&D	2116	Rockul	سر	MORYLA	02806 an
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 7 2	005 Serve	rar's Signa	ture for	w))	·	

			1 - State of Mary	-	artment of H		-	ene g. No.	18388
Н	Physici	an	Decedent's Name (First, Middle, Last) HELEN J. HARRI.	e e			2. Date of Death Month MAY 12,	Day Year	3. Time of Death 10:00 P M
	/Medic Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	MAI 12,	4c. County of De	
	7.		9021 VOLTA STREET 5. Social Security Number 6. Sex 7. Age (In	land birdhaland	LANHAM If Under 1 Year	If Under 24 Hrs.		PRINCE G	
Н	, Funeral Director		5. Social Security Number 6. Sex 7. Age (In 80	yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 5–28–24	Year) (irthplace (State or Foreign Sountry) SH., DC
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c	. City, Town or Lo	ocation	-			10d. Inside City Limits
	e Mary ia-f sh lifted	ctor	MD PRINCE GEORGE	LANHA	M				1 AYes 2 No
	with th	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What (Country?
	death ms 23	Funeral	9021 VOLTA STREET 11. Marital Status 12. Was Decedent Ever	in U.S. 13.1	207 Was Decedent of Hi	'06 ispanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No-	U. S. A.	
36	172 hours after death with the Maryland "netural", or Items 23s or 28s-1 show sideal Examinar must be notified at	by Fu	Armed Forces? 1 □ Never Married 2 【 Married 1 □ Yes 2 【 No If Yes, Give Year or Dates:		r Yes, specify Cuba 1 □ Yes 2 X □ No	Specify:	Hican, etc.)	Specify:	
9-9	72 hour netural dical Ex		15. Decedent's Education		dent's Usual Occupa		. 1	6b. Kind of Busines	BLACK s/Industry
121	fwithin 72 ho piene. r than "netur rhe Medical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. I	DO NOT use retired	during most of worki)			
d 2	Hyg the	e e	12TH GRADE 17. Father's Name (First, Middle, Last)		LIBERIAN	18. Mother's Name			AR COLLEGE
ylan	9 to 2 to 2	To B	EDWARD HATCHER				JACKSON		
Maryland 21215-0036	nd 2 ilth a 27 is r tre	l i	19a. Informant's Name/Relationship (Type, Print) YVONNE A. BOHLER-DAUGHTER			and Number or Rura E. LANHAN		City or Town, State, 706	Zip Code)
Baltimore,	ges 1 and 2 t of Health If item 27 I		20a. Method of Disposition 1 2 Burial 2 □ Cremation 3 □ Removal from State	b. Place of Dispo cemetery, cren	sition (Name of natory or other place	e) D	Date 2	0c. Location - City o	r Town, State
Itim	permit. Pages Department of h Important: If ite any injury or of		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		LN CEMETE			RENTWOOD,	MD UNERAL HOME
Ba	Depa Impo any ir		Theodore C. Tinck					, DC 2000	
			23a. Part1. Enter the disease, or complications that caused the oshock, or heart failure. List only one cause on each line. Immediate Cause (Final)	leath. Do not ente	er the mode of dying	g, such as cardiac o	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) PANCREAT: Due to (or as a condition)		R				
	Examiner								
	uted 1 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	sequence of):					
, 0	icate be executed physician and s the burial-transit		that initiated events resulting in death) Last C. Due to (or as a con	sequence of):					
68760,	icate b physic s the b	edical	d						
Вох (death certific e attending pl id for use as t	an/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □		Ectopic pregnancy			23d. Date of de	,
.O.		Physician/Me	in the past 12 months? 1		Other (specify)			Month	Day Year
٣	requires that the d een signed by the hould be detached	by Ph	Part II. Other significant conditions contributing to death but not	resulting in the ur	nderlying cause give	on in Part I.	23e. Did toba	cco use contribute	to the cause of death?
ords	v require been sig should b	leted t	BREAST CANCER				1 ☐ Yes	2 X No 3 □ F	robably 4 Unknown
Records	e law has b	Comple		-	·		24a. Was an autopsy performe	prior to death?	
Vital	ysicien: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?			26. Place of Death		No 1 □Ye	s 2□No
of	Phys this al dii	2	Hospital'	2 ER/Outpatien		4 Nuising non	ne 5 XResiden 28d. Describe how	ce 6 Other (Spe	ecify)
ion	Attending r death. ector: After by the funer	ation	1 ☐ Natural 5 ☐ Pending (Month, Day Yea 2 ☐ Accident investigation	r) Injury	Work	? (es 2 □ No		,,	
Division	or Attendated after death	ertification:	3 Suicide 6 Could not be determined 28e. Place of Injury - A building, etc. (Sp.	it home, farm, stre	eet, factory, office	2	28f. Location (Stre City or Town,	et and Number or F State)	lural Route Number,
_	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical Ce	29a. Certifier (Check only contact of the best of my 2 Medical Examiner: On the basis of examiner on the basis of examiner.	knowledge, death	occurred at the time	e, date and place, a	and due to the cau	se(s) and manner a	s stated.
	To the within 2 To the 7 Complete	Med	one) and manner stated. 29b. Signature and title of certifier		29c. License			I. Date signed (Mon	
	->-0		Q. SXlardyn		D3739	1	,	MAY 17,	2005
X	40		30. Name and address of person who completed cause of death (Print)		IRTIVITIE	MD 20721	
	Sta		31. Date filed (Month, Day, Year) MAY 1 8 2005		AU AVE. #	TOO MITCH	ւ Դ Մ Մ Ծ Ն Մ Մ Մ Մ Մ Մ Մ Մ Մ Մ Մ Մ Մ Մ Մ Մ	,, FID 2012	_
40 5	Registr	ar	MINI I O EOOS DEPLANTA	(Day					

KD			1 - State Unpend Item 23					•	ene g. No. 2005	18389
	Physici /Medic	cal	Decedent's Name (First, Middle, Last) BABBY			ANNUM		2. Date of Death Month MAY	15, 2005	3. Time of Death 10:59A. M
	Examir	ner	4a. Fecility Name (If not institution, give s 44 A Peppermint Dr 5. Social Security Number 6. Sec	IVE 7. Age (In y	rs. last birthday) Yrs.	Port De If Under 1 Year Months Days		8. Date of Birth	4c. County of Dea	thplace (State or Foreign
ý	Director wayland te show	tor	222~54~1863	44	City, Town or Lo	ocation DEPOSIT		JULY 20	,1960	DE 10d. Inside City Limits 1 □ Yes 2 ☒ No
	th with the Marylar 23a or 28a-f show ust be notified at	al Direc	10e. Street and Number 44 A PEPPERMINT I	DR.		10f. Zip Code 219	04	10	g. Citizen of What C USA	ountry?
9800	within 72 hours after death with the Maryland one. Then "natural", or ttems 23a or 28a-f show is Neufical Exart intrinsat be notified at	d by Funer	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 🎇 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🕅 No	ispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	
N		Completed by Funeral Director	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12	cation completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired MAKER	during most of wo 1)	rking	6b. Kind of Business	,
Maryland	should be filed nd Mental Hygi marked other imetic evant, I	To Be	17. Father's Name (First, Middle, Last) JACOB MOORE 19a. Informant's Name/Relationship (Ty)	na Printì	19h Maili	na Address (Street	BEATRI	me (First, Middle, M CE E. LOW		Tin Code)
	es 1 and 2 sho of Health and filem 27 is ma r othar traum		JASON LAWSON — 20a. Method of Disposition 1 □ Burial 2 XCremation 3 XR	SON 20t	44 A D. Place of Disponentery, creations	PEPPERM psition (Name of matory or other place	INT DR.,	PORT DEP	OSIT, MD 2	21904 Town, State
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or othar tr once.		*4 Donation 5 Other (Specify) 21. Signature of Funeral Service License **Author Service Licens	S	22	REMATION 2. Name and Address 4.16. PEDED	ss of Facility S		AMDEN-WYON	
	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final	e cause on each line. Multiple dru salicylate Due to (or as a cons	eath. Do not ent ig(butai intoxica sequence of):	er the mode of dyin	g, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death
k 68760,	death certificate be executed e attending physician and nd for use as the burial-transit	Medical Examiner	resulting in death) Last	Due to (or as a cons					1	
P.O. Box	that the death certifical led by the attending phy detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 X Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
Records, F	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions con	tributing to death but not	resulting in the u	nderlying cause give	en în Part I.			o the cause of death?
<u>m</u>	The ate h page	e Completed	25. Was case referred to medical	-			26 Place of Do	24a. Was an autopsy perform 15 Yes 2	ed? prior to death?	utopsy findings available completion of cause of
ō	ding Phys	ation: To Be	examiner? 1\(\tilde{\t	ospital: 1 Inpatient 2 28a. Date of Injury Fourth 1, Day Year, 5-15-05	ER/Outpatier	28c. Injun Worl	er: 4 Nursing H		ce 6 X iOther (Spe	unk
	i di di	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)	eet, factory, office		28f. Location (Stree City or Town, Port Depo	et and Number of R State) 44A Pe Sit, Md	ppermint Dr.
	the the	Medical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examir one)	ician: To the best of my ler: On the basis of exam and manner stated.	knowledge, deatl ination and/or in	h occurred at the tin vestigation, in my of 29c. Licenso	pinion, death occu	rred at the time, dat	ise(s) and manner as e and place, and due d. Date signed (Mont	e to the cause(s)
)	To To Con		· anels			OCM	1E 	MA	Y 16, 2005	5
			ANA RUBI				Street	Baltimore	, Marylan	d 21201
35	Sta Registr		31. Date filed (MoJUN, Xeal 200	31 Registrar's Sig	B A	well !				

Mark Johnson

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible

NJM	13	State of Maryland / De	partment of Health and Nertificate of Death	Mental Hygie	•
Phy	sician	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
/Me	edical	TIATE WITTIAM JOHNSON		May	15 2005 1146 ^M
Exa	miner	4a. Facility Name (If not institution, give street and number) Suburban Hospital	4b. City, Town, or Location of Death		4c. County of Death
Fune	ral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Bethesda y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgomery 9 Birthplace (State or Foreign
Direct		350.34.7213 1M 2□F 62 Yrs. Usual Residence of Decedent	Months Days Hours Min.	June 18,	ear) 9. Birthplace (State or Foreign Country) 1942 Washington
arylan show		10a. State 10b. County 10c. City, Town or MD Montgomery Chevy			10d. Inside City Limits
the M.	Director	MD Montgomery Chevy	Chase		1 ☐ Yes Ž (X No
with Sa or	5	5800 Deal Place	10f. Zip Code 20815		. Citizen of What Country?
death ms 2:	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13	3. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		J. S.A. 14. Race - American Indian.
DENTITIONE, IMBRY/IBING Z1Z13-UU36 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, IP-Maccal Exampler, nutilied at	by Fur	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White, etc. Specify: White
72 ho	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gi	edent's Usual Occupation	ing 168	b. Kind of Business/Industry
within 500.	am	Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of work . DO NOT use retired)	9	
filed v Hygie	ပိ	+4 Att	Orney	e (First, Middle, Mai	Law
Maryland d 2 should be file th and Mental Hy 7 is markad oth traumatic evans	To Be	Howard W. Johnson	Viola	Boh1ke	
Mal nd 2 st alth and 27 is n			iling Address (Street and Number or Rura Deal Place Chevy		
or Heg		20a. Method of Disposition 20b. Place of Dis			c. Location - City or Town, State
DESILLIMON Department of I mportant: If it my injury or o	0	'4 Donation 5 Other (Specify) Mt. Com	fort Crematory 5/1		lexandria, VA
permit Depart Import	SDC6		22. Name and Address of Facility $$ $$ $$ $$ $$ $$ $$ 5130 $$ $$ $$ $$ $$ $$ $$ $$ $$ $$		
Priysicia /Medic Examin	ai	23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or continuon resulting in death) a. Due to (or as a consequence of):	()		Approximate Interval Between Onset and Death
ate be executed hysician and the burial-transit	Ical Examiner	Sometially let providing	in aneungov	<i>Y</i>	
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
w requires that been signed should be del	ρ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death?
The law retate has been page 2 sho	Completed			24a. Was an autopsy performed	
sician: The certificate h	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	
Phys this c	2	1 X Yes 2 No Hospital: 1 □ Inpatient 2 X EP/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time			
ding Ph.: After	tlon	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred
Hospital or Attanding Physician: 124 hours after death. 18 Innaral Director: After this certifications by the funeral director; 19tely filled in by the funeral director;	ertification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
Hospital 24 hours a Funaral C	O	29a. Certifier 1 Certifying Physician: To the hest of my knowledge dea	Ab a constant of the disease of the		
To the Hos within 24 ho To the Funs completely f	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, dea 2 ☑ Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurre	ad at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
vith To 1	Σ	29b. Signature and title of celtifier	29c. License number		Date signed (Month, Day, Year)
1		30. Name and address of ourses who appropriate	OCME	Ma	ay, 16, 2005
(>		30. Name and address of person who completed cause obdeath (Item 23a) (Type	111 Penn Street	Baltimore	e, Maryland 21201
Regi	State strar	31. Date filed (Month, Day, Year) MAY 1 7 2005 MAY 1 7 2005	de		

		For State Registrar				Ce	rtificate	of De	ath		Re	g. No. 2 ()	105	1839
Physic	ian	Decedent's Name Decedent's Name			ac ba					M	ate of Death onth	Day	Year	3. Time of Death
/Medi		4a. Facility Name (li		erine Jo			4b. City, Tox	wn orlo	cation of De		y 12,	2005 4c. County	of Dooth	4:05 A.
Exami	ner			s Hospit		er		Chev		alli		Prince		rae's
Funeral Director	_	5. Social Security N 578-38-7	lumber 869	6. Sex 1 M 2/CXF		s. last birthday) Yrs.	If Under 1 Y	Year If	Under 24 H	in. (A	ate of Birth fonth, Day, /30/2	Year)		lace (State or Foreightry)
ow are		Usual Residence of 10a. State	10b. County		10c. C	City, Town or Lo	ocation						1	Od. Inside City Limit
Mary n-f sh	ţo	Md.	F	.G.		Fairmo	ount He	eight	s					1√ Yes 2 N
or 284	Jirec	10e. Street and Nur					10f. Zip Co				10	g. Citizen of V	What Cour	try?
23a	ral	803 57	th Plac	e				207				U.S.	.A.	
int. Pages I and z stoud be filed within 7z nouts after death with the Maryland arment of Health and Mental Hygiene. Portant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show in ury or other traumatic avant, the Medical Erathing trings to other traumatic avant, the Medical Erathing trings to other traumatic.	by Funeral Director	11. Marital Status 1 □ Nøver Marri 3 🎞 Widowed		Armed F	2 ∑N o ive		Was Decedent If Yes, specify 1 ☐ Yes 2 🙀		nic Origin? Mexican, Pu <i>pecity:</i>	(Specify Y erto Rican	es or No- etc.)	Blac	e - Am <i>e</i> nio ck, White, v:Blac	etc.
atura ical E	ted	/0	15. Decedent	's Education		16a. Dece	dent's Usual O	Occupation	1		16	6b. Kind of Bu	usiness/Inc	dustry
Med n	Completed	Elementary/Seco		t grade completed, College () (1-4or 5+)	(Give	kind of work a DO NOT use r	done durir retired)	ng most of t	vorking		White		
ygien ygien rar th	Co	12th			·	Perso	onnel S	-				J.S. G		ment
z stroud be filed within and Mental Hygiene. Is markad othar than "raumatic avant, the Me.	Be	17. Father's Name (aiden Sumam	,	
d Mer marka matic	To	JO 19a. Informant's Na		nas Harri	son	10b Mailie	ag Addross /Si					ne Mile		0-41
Ith an 17 is 18 is				n/Daught	er		ng Address <i>(Sl</i> 57th Pl							_ ′
of Heal of Heal fitam 2		20a. Method of Disp	position		20b.	Place of Dispo				Date	-	c. Location -		
rages nent of l int: If its iry or o		1 🔀 Burial 2 (' 4 □ Donation		3 □Removal from ecify)	Jale	Harmony			5/2	1/05	Lá	andove	r, Md	•
Deparment Page Manual Important: any in ury once.		21. Signature of Fu	neral Service L	. /)	tu						E. Coas	Inc.	c. 20	019
hyciolan		Immediate Cause (π tallut <i>e</i> . List o Final	complications that only one cause on	caused the dea									Approximate Interval Between Onset and Death
hysician /Medical xaminer	cal Examiner	snock, or near	Final n ditions imediate rlying injury	a. Due to	caused the deceated line. The property of as a goonse of the constant of the	ath. Do not ent		f dying, su	uch as card	iac or resp	iratory arres	t,		Approximate Interval Between Onset and Death
/Medical Examiner	edical	snock, or neal Immediate Cause (disease or condition resulting in death) Sequentially list confidence in the cause. Enter Under Cause (Disease or that initiated events	in failure. List of Final in a filtration in a	a. Due to Due to Due to	Aor as a conse	ath. Do not ent S (S) quence of): uence of): quence of):	er the mode of	dying, su	uch as card	iac or resp	iratory arres	i.	Final A	Approximate Interval Between Onset and Death
/Medical Examiner	by Physician/Medical	snock, or neal Immediate Cause (disease or condition resulting in death) Sequentially list cut if any, leading to imcause. Enter Unde Cause (Disease or that initiated events resulting in death) L IF FEMALE: 23b. Was decedent in the past 12 1	in failure. List of Final in afficient in afficient in afficient in a final i	a. Due to b. Due to c. Due to d. 23c. If yes, ou 1 Livie 4 Preg 9 Unkr	Across a consecution of pregration at time of nown	equence of): quence of): quence of): quence of): quence of):	er the mode of	d dying, su	S 4	nac or resp	B C	23d. Date Mor	e of deliventh	Approximate Interval Between Onset and Death Y Day Year e cause of death?
ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Medical	snock, or heal Immediate Cause (disease or condition resulting in death) Sequentially list configure in the cause (Disease or that initiated events resulting in death) L IF FEMALE: 23b. Was decedent in the past 12 1	in railure. List of Final in a filicins imediate riving injury .ast	a. Due to b. Due to c. Due to d. 23c. If yes, ou 1 Livie 4 Preg 9 Unkr	Across a consecution of pregration at time of nown	equence of): quence of): quence of): quence of): quence of):	er the mode of	d dying, su	S 4	ac or respond	B C	23d. Date Mor	e of deliventh	Approximate Interval Between Onset and Death O
ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical	Immediate Cause (disease or condition resulting in death) Sequentially list configures. Enter Under Cause (Disease or that initiated events resulting in death) L IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown Part II. Other significations.	in failure. List of Final in afficients in mediate riving injury .ast asst .ast .ast .ast .ast .ast .ast	a. Due to b. Due to c. Due to d. 23c. If yes, ou 4 Preg 9 Unkr	Across a consecution of pregration at time of nown	equence of): quence of): quence of): quence of): quence of):	er the mode of	nancy (y)	Part I.	2:	Be. Did toba. 1 ☐ Yes 4a. Was an autopsy performe	23d. Date Mor	e of deliventh Tibute to the 3 Proba	Approximate Interval Between Onset and Death O
After this certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Immediate Cause (disease or condition resulting in death) Sequentially list configures on the cause (Disease or candiduction of the cause (Disease or that initiated events resulting in death) L IF FEMALE: 23b. Was decedent in the past 12 1	in railure. List of Final in additions imediate riving injury last of the condition in a conditi	a. Due to b. Due to c. Due to d. 23c. If yes, ou 1 Live 4 Preg 9 Unkr	Aconse of pregration at time of nown	equence of): quence of): quence of): quence of): quence of):	DEctopic pregnil Other (specifinderlying cause	nancy fy) 26. Other: Unitry at Work?	Part I.	2: 2: 1[eath (Chei	3e. Did tobac 1 Yes 4a. Was an autopsy performe Yes 2 Eck only one) Residence	23d. Date Mor	e of deliventh ribute to th 3 Proba Were autopririor to contect? Yes er (Specify,	Approximate Interval Between Onset and Death Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and D
If the death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	ertification; To Be Completed by Physician/Medical	Immediate Cause (disease or condition resulting in death) Sequentially list confi any, leading to impact to cause. Enter Under Cause (Disease or that initiated events resulting in death) L IF FEMALE: 23b. Was decedent in the past 12 1 yes 2 yellow ye	in railure. List of Final In In In In In In In In In In In In In	a. Due to a. Due to b. Due to c. Due to d. 23c. If yes, ou 1 Live 4 Preg. 9 Unkr. as contributing to contributing to contributing to contributing to contribute the contribution of the contribution	for as a consection of pregration th. Do not ent S (S) quence of): uence of): quence of): ancy tal death 5 [death 5 [BR/Outpatien 28b. Time of Injury nome, farm, strr.	Ectopic pregn Other (specify nderlying cause t 3 DOA 28c.	nancy fy)	Part I.	22: 1[eath (Cher Home 5 28d. D	39. Did tobal 1 Yes 4a. Was an autopsy performed yes 2 Eck only one) Residence escribe how	23d. Date More 2 Mo 24b. V d? 1 1 2 2 6 Other injury occurrents and Number 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2	e of deliventh ibute to the state of the st	Approximate Interval Between Onset and Death Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and D	
Director: After this certificate has been signed by the attending physician and bir by the funeral director, page 2 should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical	Immediate Cause (disease or condition resulting in death) Sequentially list confi any, leading to improve cause. Enter Under Cause (Disease or that initiated events resulting in death) L IF FEMALE: 23b. Was decedent in the past 12 1	r failure. List of Final in afficing imediate riving injury	a. Due to b. Due to c. Due to d. 23c. If yes, out the pregent of t	for as a gonse for as a gonse for as a gonse for as a conse ath. Do not ent S (S) quence of): uence of): uence of): anancy tal death 5 (death Ectopic pregn Other (specify nderlying cause t 3 DOA 28c. M	nancy fy) 26. Other: Work? 1 □ Yes	Part I. Place of C Nursing 2 \(\) No	2: 2: 11 eath (Cher Bone 5 28d. D	3a. Did tobal 1 Yes 3a. Was an autopsy performed yes 2 Eck only one) Residence escribe how cation (Streety or Town, Streety 23d. Date Mor	e of delive nth ibute to th I proba Vere autoprior to confeath? I yes er (Specify, ed	Approximate Interval Between Onset and Death Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and D			
Director: After this certificate has been signed by the attending physician and bir by the funeral director, page 2 should be detached for use as the burial-transit	ertification; To Be Completed by Physician/Medical	snock, or heal Immediate Cause (disease or condition resulting in death) Sequentially list cut if any, leading to impact the cause (Disease or that initiated events resulting in death) L IF FEMALE: 23b. Was decedent in the past 12 1	in railure. List of Final in a structure. The structure in a struc	a. Due to b. Due to c. Due to d. 23c. If yes, out the pregent of t	Apatient 2 Department of Injury anth, Day Year)	ath. Do not ent S (S) quence of): uence of): uence of): anancy tal death 5 (death DEctopic pregn Other (specific anderlying cause to 3 DOA 28c. Meet, factory, off the restigation, in restigati	nancy fy) 26. Other: Work? 1 □ Yes	Part I. Place of E Nursing 2 No ate and plann, death occ	2: 2: 11 eath (Cher Bone 5 28d. D	39. Did tobal 1 Yes 3a. Was an autopsy performed yes 2 Eck only one) Residence escribe how cation (Street by or Town, see to the cause time, date	23d. Date Mor	e of deliventh ibute to the structure of the structure o	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset Ons	
is death. Set dea	edical Certification; To Be Completed by Physician/Medical	shock, or heal Immediate Cause (disease or condition resulting in death) Sequentially list cut if any, leading to improve cause. Enter Under Cause (Disease or that initiated events resulting in death) L IF FEMALE: 23b. Was decedent in the past 12 1	r failure. List of Final in afficient in mediate riving injury	a. Due to b. Due to c. Due to d. 23c. If yes, ou 1 Live 4 Preg 9 Unkr ns contributing to co Hospital: 1 28a. Date Mornand to be be ned g Physician: To the taminer: On the band mar	for as a gonse of oras a conse of oras oras oras oras oras oras oras oras	ath. Do not ent S (S) quence of): uence of): uence of): anancy tal death 5 (death 6 (dea	DEctopic pregn Other (specify anderlying cause M 28c. M 29c. Lice 29c. Lice 29c. Lice 29c. Lice 20c. M 29c. Lice 29c. Lice 29c. Lice 20c. M 29c. Lice 29c. Lice 29c. Lice 20c. M 29c. Lice 29c. Lice 20c. M 29c. Lice 29c. Lice 29c. Lice 20c. M 29c. Lice 29c. Lice 29c. Lice 20c. M 29c. Lice 29c. Lic	nancy fy) 26. Other: Unjury at Work? 1 □ Yes ffice	Part I. Place of E Nursing 2 No ate and plan, death oc	2: 2: 11 eath (Cher Bone 5 28d. D	39. Did tobal 1 Yes 3a. Was an autopsy performed yes 2 Eck only one) Residence escribe how cation (Street by or Town, see to the cause time, date	23d. Date Mor	e of deliventh ibute to the structure of the structure o	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset American Onset and Death Onset American Onset and Death Onset American Onset American Onset and Death Onset American Onset A
Director: After this certificate has been signed by the attending physician and bir by the funeral director, page 2 should be detached for use as the burial-transit	edical Certification; To Be Completed by Physician/Medical	snock, or heal Immediate Cause (disease or condition resulting in death) Sequentially list cut if any, leading to impact the cause (Disease or that initiated events resulting in death) L IF FEMALE: 23b. Was decedent in the past 12 1	r failure. List of Final in afficient in mediate riving injury	a. Due to Due to Due to Due to Due to Due to Due to C. Due to A Preg 9 Unkr Ins contributing to co Hospital: 1 1 28a. Date Amortical and mar And completed cause And completed cause The completed cause	gor as a gonse (or as a onse (or as a onse (or as a onse (or as a conse (or as a conse (or as a conse (or as a conse (or as a onse (or as a or as onse (or as a or as a onse (or as a or as or as or as a or	ath. Do not ent S (S) quence of): uence of): uence of): anancy tal death 5 (death 6 (dea	DEctopic pregn Other (specify nderlying cause t 3 DOA 28c. M eat, factory, off n occurred at the vestigation, in r	nancy fy) 26. Other: Work? 1 Yes ffice the time, d my opinio	Part I. Place of E Nursing 2 No ate and plan, death oc	22: 10 eath (Cheille Home 5 28d. D. 28f. Lo. Ci. Ci. Ci. Coe, and ducurred at the course of the control of the control of the course of the course of the control of the course of the c	3e. Did tobar 1 Yes 4a. Was an autopsy performe Yes 2 Eck only one) Residence escribe how cation (Streety or Town, 3) a to the cause time, date	23d. Date Mor	e of deliventh ibute to the structure of the structure o	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset Ons

			1- State of Ma	ryland / Depa		Health and N	lental Hygi	ene	10202
				Cei	uncate of	Deain		g. No. UUJ	10072
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Jung Ja Kim				May 14,	2005	9:22P M
	Examin	er	4a. Facility Name (If not institution, give street and number)			or Location of Death		4c. County of Death	
			14713 Pebble Hill Lane			thersburg		Montgomer	-
	Funeral		4 DM OFF	(In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign ntry)
	Director		561-04-4656	60 Yrs.			July 4,1	.944 Mar	yland
	and w		10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	Aary sho	ö	Manyal and Mantagement	0 - 4 + 1	1				1 ☐ Yes 2 ☑ No
	28a-	Director	Maryland Montgomery 10e. Street and Number	Gaithe	10f. Zip Code		10	g. Citizen of What Cou	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Modical Examination and once.					20070			
	s 23	Funeral	14713 Pebble Hill Lane			20878		nited Stat	
	er de	n n	11. Marital Status 12. Was Decedent I Armed Forces?		f Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	14. Race - Ameri Black, White,	
36	s aft	by F	1 M Never Married 2 Married 1 Yes 2 M N 1 Yes, Give 1 Yes, Give Year or Dates:		1 ☐ Yes 2 🎇 No	Specify:		Specify: As	Lan
Ş	hour tural	å E	15. Decedent's Education	160 Dage	dent's Usual Occup	nation		Ch. Kind of Duniana da	d
5	n 72 "na	Completed	(Specify onfy highest grade completed)	(Give	kind of work done	during most of work od)	ing	6b. Kind of Business/In	dustry
12	withi ene. than	μ	Elementary/Secondary (0-12) College (1-4or 5	+)	atory Te			NIH	
Maryland 21215-0036	Hygi Hygi ther int,		17. Father's Name (First, Middle, Last)	nabor.	acory re-	,	e (First, Middle, M		
ä	be o be	Be						ardon burnamo)	
Ë	J Me J Me nark natio	ပ္	Sang Jin Kim	20/11/19		Soon Ja			
Ja	l 2 st)	19a. Informant's Name/Relationship (Type, Print)					City or Town, State, Zip	
	and lealth m 27 her t	1 3	Sook Ja Choi (sister					ina, CA 91	
ore	P is T		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State	20b. Place of Dispo				Oc. Location - City or To	own, State
E	Pag ment ant: ury c	1 2	'4 ☐ Donation 5 ☐ Other (Specify)	Metropoli	tan Crema	atory $5/17$	7/05 A	lexandria,	Virginia
Baltimore,	porting y inj	1 7	21. Signature of Funeral Service Licensee	22	. Name and Addre	ess of Facility De	Vol Funer	al Home	
m	8 9 E 8 8		TERY A. Stuver					rsburg, MD	. 20877
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir	the death. Do not ent					Approximate Interval Between
	Physician		Immediate Cause (Final		n	_			Onset and Death
	/Medical		resulting in death)	ocellular (Jarcinoma	<u>a</u>			6 Months
	Examiner		Chron	ic Hepatit:	ic R Info	action			Years
		e		consequence of	re p lure	ection			icars
	ted nsit	- Lu	cause. Enter Underlying Cause (Disease or injury						
	be executed ician and burial-transit	Examiner	triat initiated events	a consequence of):					
760,	be executed sician and burial-transit	calE	· -						
687	# × @	edlc	d						
×	law requires that the death certifica as been signed by the attending ph 2 should be detached for use as the	/Me	IF FEMALE: 23c. If yes, outcome	of programov					
Вох	ath c	lan	in the past 12 months?	2 ☐ Fetal death 3 ☐	Ectopic pregnanc	у		23d. Date of deliver	Day Year
0	e de the a	/slc	1 ☐ Yes ※☐ No 4 ☐ Pregnant at 9 ☐ Unknown	time of death 5L	Other (specify) _				
<u>G</u>	d by	Physician/M		A A			OD- Didash		and an unit of days the
ŝ	es the	by	Part II. Other significant conditions contributing to death be	it not resulting in the ur	nderlying cause giv	ven in Part I.		cco use contribute to the	
5	w require been si should I	ted					1 ∐ Yes	2 X No 3 ☐ Prot	ably 4 Unknown
Records,	aw r	Completed					24a. Was an autopsy		psy findings available
	0 5 0	Eo					performe	ed? death?	mpletion of cause of
Vital	ician: Th certificate ector, pag	0	25. Was case referred to medical			26 Place of Deat	h (Check only one		200110
	Physician: rthis certifica ral director, p	0 8	examiner? 1 ☐ Yes 2 🏋 No Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatien	t 3 DOA Ott	non		ce 6 □Other (Specif	v)
of	Phy ir this aral o	\vdash	27. Manner of Death 28a. Date of Injur	y 28b. Time of	28c. Inju	ry at	28d. Describe how		y)
on	Attending r death. actor: After by the funer	tlor	1 XNatural 5 ☐ Pending (Month, Day 2 ☐ Accident investigation	Year) Injury	Wo	rk?]Yes 2 ☐ No			
S	deal ctor y the	fica	3 Suicide 6 Could not be	ry - At home, farm, stre			28f Location (Stre	et and Number or Rura	al Route Number
Division	in Little	Certification:	4 H Hicide determined 200. Place of Into	. (Specify)	oot, ractory, ornoe		City or Town,		i ricato ramber,
_	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 1 X Certifying Physician: To the best of	i mu knowlade - de-ti	aggurant of the .	mo dota and all	and due to the		
	Hos 24 hc Fun fely	edical	(Checklonly 2 Medical Examiner: On the basis of	examination and/or inv	restigation, in my	me, date and place, opinion, death occuri	and due to the cau red at the time, dat	se(s) and manner as s e and place, and due to	tated, the cause(s)
	the thin the the mple	Med	29b. Signature and the of certifier	teu.	29c. Licens	se number	20.	d. Date signed (Month,	Day Yearl
	Wil To	-	255. Signature and the obtaining			172242			•
•	15		10		ש.נ.	1/444	M	ay 16, 2005	,
	•	1	30. Name and address of person who completed cause of de	eath (Item 23a) (Type,	Print)				
			W. Scott Schroth, MD - 2150	Pa. Ave.,	NW - Wa	shington,	D.C. 2	0037	
	Sta		31. Date filed (Month, Day, Year) 82. Registra	r's Signature	00				
	Registr	ar	MAY 1 7 2005 Kenetic	ff. Apart					

			1 - For State Registrar	State of Marylar		artment rtificate			ind M e		iene eg. No. 20	05	18393					
1	Physic /Medi			Jordan Krey	ling				1	May 13,		Year	3. Time of Death					
	Examir	ner	4a. Facility Name (If not institution, give Anne Arundel Medic 5. Social Security Number 6. Se	cal Center	last hirthday)	4b. City, T Annaj If Under 1	poli	ocation of S If Under 2		3. Date of Birth	4c, County Anne	Arun						
	Funeral Director			ØM 2□F 73	Yrs.		Days	Hours	Min.	Mar. 11	,1932	Geor	lace (State or Foreign try) gia					
	the Maryian 28a-f show	Director	MD Anne Arus 10e. Street and Number		ty, Town or Lo						0g. Citizen of W		0d. Inside City Limits X Yes 2 □ No					
	ath with 23a or ust be		307 C Burnside S	treet		2140					nited S		,					
920	72 hours after death with the Maryland Instural', or Itams 23a or 28a-1 show Jissal Examinar must be positived at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Types 2 No 12 If Yes, Give 11-2 Year or Dates: 11-2	2 55	Was Decede f Yes, specif 1 ☐ Yes 2		panic Orig , Mexican, Specify:	in? (Speci Puerto Ri	fy Yes or No- can, etc.)	Black	- Americ k, White, c	etc.					
Maryland 21215-0036	d within jiene. r than r e Me	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12		(Give life. L	tent's Usual kind of work DO NOT use ierge	Occupat done du retired)	ion ering most	of working	'	16b. Kind of Bu Yacht C		lustry					
yland 2	e file of hay vent,	To Be C	17. Father's Name (First, Middle, Last) Bobby Kreyling			-	ľ	Margi	e		Maiden Sumame	(MN 1	not avail.)					
	and 2 sh salth and 1 27 is m ar traum		19a. Informant's Name/Relationship (7 Sean J. Kreyling	ype, Print) (son)							City or Town, S WA 9811		Code)					
Baltimore,	permit, Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 is marked any injury or other traumatic e once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State) Met	Place of Disposemetery, crem repolitar	natory or oth	ier place,	M	Dat Æy 17. 2005		20c. Location - (Alexandria							
Balt	permit, Depart Import any inj		21. Specific (For fall evice Licens	X M0098	32 42	Hudson	n St.	Suite	110 A	nnapolis	al & Cren , Marylar	nation nd 214	Service 01					
1	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ilications that caused the dealine cause on each line. a. Due to (or as a consec	01	er the mode	of oving,	such as c	ardiac or r	espiratory arre	V.	ase	Approximate Interval Between Onset and Death					
8760,	death certificate be executed e attending physician and for use as the burial-transit	Physician/Medicai Examiner	Sequentially list conditions, if any leading immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect. Due to (or as a consect.)														
.O. Box 6	death cert e attending ed for use a		ysician/Med	ıysician/Med	nysician/Med	nysician/Med	nysician/Med	nysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn: 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	Ideath 3 🗌	Ectopic pred					23d. Date Mon	of deliver
rds, P	sign sign d be	٥	Part II. Other significant conditions co	ntributing to death but not res	ulting in the un	iderlying cau	rse diveu	in Part I.		23e. Did tob	_ `		e cause of death?					
Vital Records,	≥	Completed							-	24a. Was ar autopsy perform 1 \sum Yes 2	pr led2 de	rior to com eath?	sy findings available indicate of 2 No					
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient	t 3□ DOA	Other			Check only one								
ion of	ding h. After fune	ation; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		c. Injury a Work?		280		nce 6 Othe winjury occurre							
Division	Dir	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special		et, factory, o	office		28	Location (Str City or Town	eet and Numbe State)	r or Rural	Route Number,					
	To tha Hospital within 24 hours a To the Funaral I completely filled	Medicai	29a. Certifier Certifying Phy Certifying Phy 2 Medical Exam	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at estigation, in	the time n my opir	, date and nion, death	place, and occurred	d due to the ca at the time, da	use(s) and man te and place, ar	ner as sta nd due to	ited. the cause(s)					
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	MD		29c. 1	License r	number (8	> 7	29	d. Date signed	(Month, D	ay, Year)					
			30. Name and address of person who c	ompleted cause of death (Iter	n 23a) (Type, f	Print)		Aren	10	M	edica		Center					
	Sta	te	31. Date filed (Month, Day, Year)	32. Pigistrar's Signa	iture	·												

			1- For State of Maryland / Dep	artment of Health and M		giene 005 18394
			Decedent's Name (First, Middle, Last)		2. Date of Dea	ath 3. Time of Death
	Physici /Medi		Margaret Ann Kuhn		Month May	Day Year 15 2005 8:45 p M
all l	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	naj	4c. County of Death
			3221 Throne Drive	Dunkirk		Calvert
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours Min.	8. Date of Birt (Month, Day	h 9. Birthplace (State or Foreign Country)
	Director		578-54-5968 1 62 Yrs. Usual Residence of Decedent		June 28	3, 1942 Washington, DC
	land ow		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Man,	ţ	Maryland Calvert Dunkirk			1∑Yes 2 □ No
	n the	Directo	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?
	h with	a D	3221 Throne Drive	20754	-	U.S.A.
	ems erm	Funerail	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13.	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	
90	or Ite	正	II YAS GWA	1 Yes 2X No Specify:	nican, etc.)	Black, White, etc. Specify: White
8	72 hours after death with the Maryland natural', or tems 23a or 28a-f show disal Examirac must be rodified at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			Specily: WILLE
15-	"nat	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of workin DO NOT use retired)	ng	16b. Kind of Business/Industry
112	withi	m c	Elementary/Secondary (0-12) College (1-4or 5+)	etary		State Farm Insurance
p	o filed Hyg other ent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name		
Maryland 21215-0036	uld be denta rked tic ev	To B	Richard M. Shaw	Doris Bur	den	
ary	shou and N s ms	_	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ng Address (Street and Number or Rural		r, City or Town, State, Zip Code)
Σ	and 2 salth n 27 i			Throne Drive, Dunk	kirk, Ma	aryland 20754
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a -f show any figury or other traumatic event, the Madical Evantment must be notified at anone.		20a. Method of Disposition 1 ☐ Burial ¬2 ☒Cremation 3 ☐Removal from State 20b. Place of Disposition cemetery, cre	osition (Name of Date	ate	20c. Location - City or Town, State
Ē	Pages ment of h ant: If Ite			itan Crematory 05/1	18/05	Alexandria, Virginia
3all	Depart Depart Import any in		21. Sign ture of Funeral Symbol 1. nsee	2. Name and Address of Facility Gas	sch's F	uneral Home, P.A.
	0.01 = 40 OI		Toute 1 pg	4739 Baltimore Aver	nue, Hya	attsville, MD 20781
I.			23a/ Pan1. Enter the disease, or/complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or	respiratory arr	rest, Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Chronic Obstructiv	ve Pulmonary Diseas	se	Decades
	Examiner		Due to (or as a consequence of):			
	E HIN	e	Sequentially list conditions, b. Due to (or as a consequents of):			
	uted d ansit	m F	cause. Enter Underlying Cause (Disease or injury			
á	exec an an rial-tra	Examiner	resulting in death) Last Due to (or as a consequence of):			
8760,	cate be executed physician and the burial-transit	Physiclan/Medical	d			
9	ntifica ng ph as th	Med	IF FEMALE:			
Вох	death certific e attending p id for use as	lan/I	23b Was decedent pregnant 23c. If yes, outcome of pregnancy	Ectopic pregnancy		23d. Date of delivery
o.	0 0	/sicl	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown	Other (specify)		Month Day Year
<u>a</u>	The law requires that the tee has been signed by the bage 2 should be detached.		Part II. Other significant conditions contributing to death but not resulting in the u	nderhing cause groon in Part I	23a Did to	bacco use contribute to the cause of death?
ds,	signed to det	d by	The state of the s	manying cause given in rate i.		es 2 No 3 Probably 4 Unknown
Record	w require been sig	ompieted				
Re	hysician: The law his certificate has I I director, page 2 s	п			24a. Was a autops perform	prior to completion of cause of
g		e Co	25. Was case referred to medical		1 ☐ Yes	2X No 1 Yes 2 No
>	Physician; this certificaral director, I	0	examiner? 1 Yes 2X No	26. Place of Death		ence 6 □Other (Specify)
0	<u>a</u> = <u>a</u>	L'i	27. Manner of Death 28a. Date of Injury 28b. Time of			ow injury occurred
0	Attending r death. ector: After by the funer	atlo	1 X Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	M 1 Yes 2 No		
Division of Vital	or Atten after deat Director: in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, sti building, etc. (Specify)	eet, factory, office 28	8f. Location (St City or Town	reet and Number or Rural Route Number,
	Hospita 14 hours Funeral tely fillec	edical	29a. Certifier (Check only (n occurred at the time, date and place, an	nd due to the ca	ause(s) and manner as stated.
	To the Hospital or within 24 hours after to the Funeral Dir. completely filled in I.	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number		9d. Date signed (Month, Day, Year)
	8484		Vita le Marie			
0	Tin		30. Name and address of person who completed cause of death (Item 23a) (Type,	D22780		May 16, 2005
X	1 (2)			yay Center Drive, G	reenbe1	t, Maryland 20770
	Sta		31. Date filed (Month, Day, Year) 32 Registrar's Signature			-,
	Registra	ar	MAY 1 8 2005 Kelen & Spa	de .		

			State of Maryland / Departmen	nt of Health and Material Mate	lental Hygie	-	18395
			1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici /Medio		Alejandro Leon		Month May 1	Day 2005	3:18 P M
	Examir			, Town, or Location of Death		4c. County of De	
н			Shady Grove Adventist Hospital Roc	kville		Montgome	127
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Unde	r 1 Year If Under 24 Hrs.	8. Date of Birth		Sirthplace (State or Foreign Country)
	Director		225-21-8836 X X 2 F 70 Yrs. Months	Days Hours Min.	(Month, Day, Y	1934 P	eru
	p ,		Usual Residence of Decedent				
	aryla shov	<u>.</u>	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	88a-f	Directo	Maryland Montgomery Silver Spring			-	1 Yes 2 □ No
	or 2	ä	10e. Street and Number	D Code	10g	. Citizen of What	Country?
	ath v	ral		906		S.A.	
	er de Itami	nue	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Dece Armed Forces? 13. Was Dece	dent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi	nerican Indian, nite, etc.
36	s aft	by Funeral	1 □ Never Married 2/2 Married 1 □ Yes 2/2 No 1 □ Yes Give 1X□ Yes 3 □ Widowed 4 □ Divorced Year or Dates:	2□No Specify: Peri	uvian	Specify: W	hite
Ş	72 hours after death with the Maryland 'natural', or Itams 23a or 28a-f show dical Examinar must be notified at	pa th	3 \(\text{Widowed 4 \(\text{Divorced} \) Year or Dates: \(\text{15. Decedent's Education} \) 16a. Decedent's Usu	al Convention	1.40		
21215-0036	in 72 an" r	Completed	(Specify only highest grade completed) (Give kind of we	ar occupation ork done during most of worki ise retired)	ing 16	b. Kind of Busines	ss/industry
7	with than	Щ	Elementary/Secondary (0-12) College (1-4or 5+) 4 Driver			Food Ser	wi a c
D	Hyg other ent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma.		vice
au	ld be ental kad ic ev	To B	Ubaldo Leon	Sara Zapa	ata		
Maryland	shound M	-		s (Street and Number or Rura		ity or Town. State	. Zip Code) 20006
Š	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healih and Mental Hygiena. Department of Healih and Mental Hygiena. Insportment of Healih and Mental Hygiena. Insportment of the Traumatic event, the Madical Examinar must be notified at once.			leyfield Dr. A			pring, MD.
Baltimore,	Ogh it Heg		20a. Method of Disposition 1 Removal from State 20b. Place of Disposition (Na cametery, crematory or cametery, crematory or cametery).			c. Location - City of	
Ë	Page ent o nt: If ry or		1 ဩBurial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) National Memo:	may 2	22,	11a Chum	oh Wissinia
Ħ	artm orta		the state of the s	nd Address of Facility Jos			ch, Virginia
ä	per fimp any			isconsin Ave.	-		
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the more shock, or heart failure. List only one cause on each line.				Approximate
			Immediate Cause (Final	/ 1			Interval Between Onset and Death
	Priysician /Medical		disease or condition resulting in death) a	BLEED			6 DAYS
Н	Examiner		14 4 PER TENICIA	640			20 YEARS
		ē	Sequentially list conditions, if any, leading to intrindiate b. Due to (cr as a consequence of).	N			100
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events				
o,	exad an an rial-tr		resulting in death) Last Due to (or as a consequence of):				
8760,	The law requires that the death certificate be executed ta has been signed by the attending physicien and hage 2 should be detached for use as the burial-transit	cal	d				
9	tifica ig ph as th						
Вох	h cer endir use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of d	elivery
	deat e att	Cla	in the past 12 months? 1 Yes 2 No 1 Live birth 2 Fetal death 3 Ectopic p 4 Pregnant at time of death 5 Other (sp			Month	Day Year
O.	at the by th tache	hys	9 Unknown				
	res that the death certifica igned by the attending pl be detached for use as t	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying of	ause given in Part I.	23e. Did tobac	co use contribute	to the cause of death?
ğ	w require bean sign should b				1 🔲 Yes	2.□No 3□F	Probably 4 Unknown
Records,	awre as be 2 sho	plet			24a. Was an		autopsy findings available
	The lay	Completed			autopsy performed	1? death?	
Vital	ysician: The is certificata h: director, page	a	25. Was case referred to medical	26. Place of Death	(Check only one)	NO TOTAL	s 2 No
	Attending Physician: r death. actor: After this certific. by the funeral director,	ToB	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DC	Other	me 5 Residence	e 6 Other (Sp	ecify)
0	ding Phy th. After thi funeral o				28d. Describe how i		,
<u>ö</u>	ttendin death. ctor: Af y the fur	ertification:	1 □ Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation M	1 ☐ Yes 2 ☐ No			
Division of	or Atten after deat Diractor: in by the	tific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	y, office 2			Rural Route Number,
ฉี	To the Hospital or At within 24 hours after or To the Funeral Dirac completely filled in by	Cert	bunung, atc. (Spacity)		City or Town, S		
	e Hospital 124 hours a e Funeral letely filled	edical	29a. Certifier (Check only (Ch	at the time, date and place, a	and due to the caus	e(s) and manner a	as stated.
	To the H within 24 To the F complete	ledi	and manner stated.				
	To To	Σ	29b. Signature and title of certifier 29c	c. License number	29d.	Date signed (Mor	nth, Day, Year)
	5		NIT P. KURIVILLA IND	940187	Me	11 19	, 2005
)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
			ASIT T. KUKUNICA, MD, 1/125 Kox	-KVILIE FIKE	, #208 R	dekulle	mo 2085
	Sta		31. Date filed (Month, Day, Year) MAY 1 7 2005 33 Registrar's Signature		/		/
	Registr	ar	MINI T (COO?				

			1 - For State Registrar	State of Maryl	and / Depa		ealth and M	ental Hyg	iene _{eg. No.} 2005	18396					
	Physic /Medi Examir	cal	1. Decodent's Name (First, Middle, Last 4a. Eacility Name (If not ingitution, give	V Jay	fiel.	4b. City Town, of L		2. Date of Dear		3. Time of Death 10.30 AM					
	Funeral Director		5. Social Security Number 6. Se 219–46–4388 139 Usual Residence of Decedent	7. Age (In 56	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Ars. Hours Min.	8. Date of Birth (Month, Day, 5/31/19	Year) 9. Big 48 Mar	rthplace (State or Foreign country) Cyland					
	the Maryland 28e-f show notified at	ector	10a. State 10b. County Maryland Wicomic 10e. Street and Number		City, Town or Lor				0.0	10d. Inside City Limits Yes 2 No					
	th with 23a or 1st be	al Di	PO Box 1733			21802			0g. Citizen of What C USA	ountry ?					
9036	be filed within 72 hours after death with the Maryland tal Hygiene. dother than "neturel", or Items 23a or 28e-1 show event, the Medical Exarterer rust be notified at	d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ▼ Divorced	12. Was Decedent Ever in Armed Forces? ↑ Yes 2 □ No If Yes, Give Year or Dates.	14	Vas Decedent of Hisp Yes, specify Cuban, ☐ Yes 2 ☑ No	panic Origin? (Spe , Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi						
21215-0036	<i>i</i> ithin 72 h ne. h an "netu e wedical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	ication	(Give)	ent's Usual Occupati kind of work done du O NOT use retired)	ion ring most of workin	1	16b. Kind of Business						
d 21	filed Hygi ther		12 17. Father's Name (First, Middle, Last)		Elect	rician 1	8. Mother's Name		Choptank E	lectric					
Maryland	should be and Mental marked c	To Be	Samuel Layfield				Pearl Ma	thilda 1	Ellis						
Mar	d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2		19a. Informant's Name/Relationship (T) Lola M. Bozman/au						City or Town, State,	Zip Code)					
ore,	item item		20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ F	20	b. Place of Dispos	Cherry Wa ition (Name of atory or other place) Memorial	D	ate	20c. Location - City or	Town, State					
Baltimore,	permit. Pages Department of I Important: If it any injury or o	-	' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal Funeral Service Licens		Park		0,10,		Salisbury,						
Ba	permit. Departimports any inji	<	1000		CFSP 50	lloway Fu 1 Snow Hi	neral Ho 11 Rd	me Profe Salisbu	essional A cy, MD 218	ssociation					
No. of the last	Pnysician /Medical Examiner	ner	23a. Part1. Enter the disease, or complishock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)	ne cause on each line.	STA (sequence of):	r the mode of dying, CR 41		, ,	,	Approximate Interval Between Onset and Death Warning					
8760,	ate be executed obysician and the burial-transit	Physician/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cond	sequence of):										
P.O. Box 68	the death certificat by the attending phy ached for use as th		ysician/Me	ysician/Med	nysician/Med	hysician/Me	hysician/Med	nysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3 🔲	Ectopic pregnancy Other (specify)			23d. Date of de Month
	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions cor	ntributing to death but not	resulting in the un	derlying cause given	in Part I.		acco use contribute to s 2 □ No 3 □ Pr	3.0					
tal Records,	The la ate has page 2	tion: To Be Completed		25. Was case referred to medical			2	26. Place of Death		ed? prior to death? 1 ☐ Yes	utopsy findings available completion of cause of				
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.		examiner? 1 Yes 2 No F 27. Manner of Death Natural 5 Pending Accident investigation	fospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year	28b. Time of Injury	3 DOA Other: 28c. Injury at Work?	4 Nursing Hom	e 5 Reside		city) HOSPICZ					
É	tel or Atters after de el Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	at home, farm, stre	et, factory, office	2	Bf. Location (Str. City or Town,	eet and Number or Ru State)	ural Route Number,					
	e Hospitel 24 hours a Funerel I etely filled	edical	29a. Certifier Check only one) Certifying Physical Examination	sician: To the best of my liner: On the basis of exame and manner stated.	knowledge, death ination and/or inve	occurred at the time, estigation, in my opin	date and place, ar	nd due to the ca d at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)					
	To the within 2 To the complet	₹	29b. Signature and title of certifier			29c. License n			d. Date signed (Mont	· · · · · · · · · · · · · · · · · · ·					
	J8.00		30. Name and address of porses who are	mpleted cause of don't (Shin	D00:	58410	ع د	5/15/	105					
	20		6 Hum WAM	10 0101	6 AR	ROWWO	OD CT	SAL	15134RY	140.21801					
	Sta Registr	te ar	31. Date filed (Month, Day, Year)	05 32. Sistrar's Signature	gnature										

		1 - State Registrar 1. Decedent's Name (First, Middle,	Last)		ertificate o	Deam	2. Date o	Reg. No	. C. U	3. Time of Death
Physici /Media		Harold	Leyh				May 1	3, 200)5 Y	1005 A
Examir		4a. Facility Name (If not institution,	give street and number)		4b. City, Town			4c.	. County of [
Funeral		241 Tilden Way 5. Social Security Number	6. Sex 7. Age (Ir	n vrs. last birthday	Edgewat		4 Hrs. 8. Date of		ne Ar	
ector		214-52-5548 Usual Residence of Decedent	¹X™ 2□ F 61	Yrs.	Months Day	s Hours	Min. 3–28-	Day, Year) -1944	(Birthplace (State or Forei Country) Germany
if itam 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic evant, Its Madical Examiner must be multired at	Director	-	Arundel	c. City, Town or L Edge	water					10d. Inside City Limit
	DI	10e. Street and Number 241 Tilden Way			10f. Zip Code 210				izen of Wha JSA	t Country?
	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.			in? (Specify Yes or Puerto Rican, etc.)		14. Race - A	American Indian,
	by	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 🌠 Divorced			1 ☐ Yes 2 💢 N		rueno nican, etc.		Specify:	White, etc. White
	Completed	15. Decedent's (Specify only highest	grade completed)	(Give	edent's Usual Occ e kind of work don DO NOT use retii	ne durina most	of working		nd of Busine	ess/Industry
	Com	Elementary/Secondary (0-12) 12th	College (1-4or 5+)		ardener	Busines	s Owner		motive irdeni	ng –
	Be	17. Father's Name (First, Middle, L.	ast)				's Name (First, Mio		,	
	2	Carl Leyh 19a. Informant's Name/Relationshi	n (Type Print)	19h Mail	ing Address (Strag	ot and Number	Margar or Rural Route Nu		_	7.0.1
		Angelika P. Ou			Kimberl		Stevensy			
once.	16	20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from State	Ob. Place of Disp cemetery, cre			Date			or Town, State
	1	'4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Li	ecify)		rematory		5–19–05		rewate:	
ouce		· foluto la	rl-	2	2. Name and Add	ress of Facility	George	P. Kal	as Fu	neral Home , MD 21037
		23a. Part1. Enter the disease, or c							water	, LU 21037
ion		SHOCK, OF HEAR FAILURE. LIST OF	omplications that caused the nly one cause on each line.	death. Do not en	ter the mode of dy	ying, such as c	ardiac or respirator	y arrest,		Approximate Interval Between Onset and Death
an cal		shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	omplications that caused the nly one cause on each line. a. Alboros Due to (or as a co	death. Do not en	ter the mode of dy	ying, such as c		y arrest,		Approximate Interval Between
al.	_	Immediate Cause (Final disease or condition resulting in death)	a. Attovos Due to (or as a co	death. Do not en	ter the mode of dy	ying, such as c	ardiac or respirator	y arrest,		Approximate Interval Between
al.	niner	Immediate Cause (Final disease or condition resulting in death)	a. Atheros	death. Do not en	ter the mode of dy	ying, such as c	ardiac or respirator	y arrest,		Approximate Interval Between
eal ier	Examiner	Immediate Cause (Final disease or condition	a. Attovos Due to (or as a co	death. Do not en	ter the mode of dy	ying, such as c	ardiac or respirator	y arrest,		Approximate Interval Between
al.	Ä	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated eyents	a. Attorios Due to (or as a co	death. Do not en	ter the mode of dy	ying, such as c	ardiac or respirator	y arrest,		Approximate Interval Between
eal ier	Ä	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Attorios Due to (or as a co	death. Do not en	ter the mode of dy	ying, such as c	ardiac or respirator	y arrest,		Approximate Interval Between
al er	Ä	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Attorios Due to (or as a co	death. Do not en	ter the mode of dy	ying, such as c	ardiac or respirator	y arrest,		Approximate Interval Between Onset and Death
al.	Physiclan/Medical Ex	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \)	a. Due to (or as a co	death. Do not en	Ter the mode of dy COVAL CovAL Co	ying, such as c	ardiac or respirator	y arrest, Seas	C. Sd. Date of Month	Approximate Interval Between Onset and Death
er	by Physiclan/Medical Ex	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	a. Due to (or as a co	death. Do not en	Ter the mode of dy COVAL CovAL Co	ying, such as c	ardiac or respirator	y arrest, Seas	3d. Date of Month	Approximate Interval Between Onset and Death delivery Day Year
d,	by Physiclan/Medical Ex	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	a. Due to (or as a co	death. Do not en	Ter the mode of dy COVAL CovAL Co	ying, such as c	23e. Di	d tobacco us	3d. Date of Month Se contribute No 3 24b. Were prior t	Approximate Interval Between Onset and Death Onset and Death delivery Day Year to the cause of death? Probably 4 Aunknown autopsy findings available to completion of cause of
er	Completed by Physiclan/Medical Ex	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition	a. Due to (or as a co	death. Do not en	Ter the mode of dy COVAL CovAL Co	ying, such as co	23e. Di 24a. W at 12 Yes	d tobacco us Yes 2 as an topsy riformed? s 2 No	3d. Date of Month Se contribute No 3 24b. Were	Approximate Interval Between Onset and Death Onset and Death delivery Day Year to the cause of death? Probably 4 Aunknown autopsy findings available occupietion of cause of
al er	Be Completed by Physiclan/Medical Ex	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	a. Due to (or as a co b. Due to (or as a co c. Due to (or as a co d. Due to (or as a co d. Due to (or as a co d. Due to (or as a co d. Due to (or as a co d. Due to (or as a co d. Due to (or as a co d. Due to (or as a co	death. Do not en	Dectopic pregnand Other (specify)	cy 26. Place o	23e. Di 24a. W 25 t Death (Check on)	d tobacco us Yes 2 as an topsy informed? s 2 No	3d. Date of Month Se contribute No 3 24b. Were prior 1 death	Approximate Interval Between Onset and Death Onset and Death delivery Day Year probably 4 Aunknown autopsy findings available completion of cause of es 2 \square\$No
al er	To Be Completed by Physiclan/Medical Ex	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, frank, reading to minimulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	a. Due to (or as a co b. Due to (or as a co c. Due to (or as a co d. Due to (or as a co d. Due to (or as a co d. Due to (or as a co d. Due to (or as a co d. Due to (or as a co d. Due to (or as a co d. Due to (or as a co	regnancy Fetal death 5 of death 5 of resulting in the u	□Ectopic pregnan: □ Other (specify) □ Indertying cause g	cy 26. Place o	23e. Di 24a. W 25 t Death (Check on)	d tobacco us Yes 2 as an topsy flormad? s 2 No y one) asidence 6.	3d. Date of Month se contribute No 3 24b. Were prior 1	Approximate Interval Between Onset and Death Onset and Death delivery Day Year probably 4 Aunknowr autopsy findings available completion of cause of 2 No
al er	To Be Completed by Physiclan/Medical Ex	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, frank, feating in death) Sequentially list conditions, frank, feating in death) Sequentially list conditions, frank, feating in death) Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a co b. Due to (or as a co c. Due to (or as a co d. Due to (or as a co	regnancy Fetal death 5 of death 5 of resulting in the u	□Ectopic pregnan □ Other (specify) □Int 3□ DOA Of 28c. Inju	cy 26. Place o ther: 4 \(\text{ Nurs ury at 1.} \)	23e. Di 24a. W 25 Period of Descrit	d tobacco us Yes 2 as an topsy informed? s 2 No y one) ssidence 6. e how injury	3d. Date of Month Se contribute No 3 24b. Were prior 1 death 1 Y Other (S)	Approximate Interval Between Onset and Death Onset and Death delivery Day Year probably 4 Aunknowr autopsy findings available completion of cause of 2 No
er	ertification: To Be Completed by Physiclan/Medical Ex	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a co b. Due to (or as a co c. Due to (or as a co d. Due to (or as a co	regnancy [Fetal death 5] of death 5] of death 5] of death 5] of resulting in the u	□Ectopic pregnan □ Other (specify) □Int 3□ DOA Of 28c. Inju	cy 26. Place o ther: 4 \(\text{ Nurs ury at 1.} \)	239. Di 24a. W au pe 1 Death (Check onling Home 5 Re 286. Describ	d tobacco us Yes 2 as an topsy informed? s 2 No y one) ssidence 6. e how injury	3d. Date of Month Se contribute No 3 24b. Were prior 1 death 1 27 Coccurred	Approximate Interval Between Onset and Death Onset and Death delivery Day Year probably 4 Aunknowr autopsy findings available completion of cause of 2 No
eal	Certification: To Be Completed by Physiclan/Medical Ex	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, frank, feating in death) Sequentially list conditions, frank, feating in death) Sequentially list conditions, frank, feating in death) Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a co b. Due to (or as a co c. Due to (or as a co d. Due to (or as a co	regnancy Fetal death 5 of death 5 of resulting in the u 2 ER/Outpatier 28b. Time of Injury At home, farm, stropecify)	□Ectopic pregnan □ Other (specify) □ anderlying cause g □ 28c. Inju Wc M 1 □ □ ceet, factory, office	cy 26. Place of ther: 4 \(\text{Nurs} \) 179 4 2 \(\text{Nurs} \)	23a. Di 24a. W au au at the second of the se	d tobacco us Yes 2 as an topsy ridrymed? s 2 No y one) sidence 6. y how injury (Street and fown, State)	3d. Date of Month Se contribute No 3 24b. Were prior I death 1	Approximate Interval Between Onset and Death Onset and Death delivery Day Year p to the cause of death? Probably 4 Aunknowr autopsy findings available ocompletion of cause of eas 2 No pecify) At Scene
al er	ertification: To Be Completed by Physiclan/Medical Ex	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a co b. Due to (or as a co c. Due to (or as a co d. Due to (or as a co	regnancy Fetal death 5 of death 5 of resulting in the u 2 ER/Outpatier 28b. Time of Injury At home, farm, stropecify)	Deet, factory, office	cy 26. Place of ther: 4 \(\text{Nurs} \) 179 4 2 \(\text{Nurs} \)	23a. Di 24a. W au au at the second of the se	d tobacco us Yes 2 as an topsy riformed? s 2 No y one) ssidence 6. ye how injury (Street and fown, State) the cause(s) as a date and fown, date and fown date and fow	3d. Date of Month Se contribute No 3 24b. Were prior I death 1	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death? Probably 4 Aunknowr autopsy findings available completion of cause of es 2 No pecify) At Scene

			1 - For Stata Registrar	State of Mar		artment rtificate				fental l	Hygie Rag.	_6.01	15	183	398
	Physic	ian	1. Decedent's Name (First, Middle, La							2. Date of Month		Day 2005	Year	3. Time of	
	/Medi	cal	Dillard Grant 4a. Facility Name (If not institution, giv		г.	4b Ciby 7	Town or	Location o	of Dooth	May	14,	4c. County of	f Dooth	4:50	P ^M
	Exami	ier	Bradford Oaks Nu		ab.		nton		n Death			Prince		roe!e	
	Funeral		Social Security Number 6. S	ex 7. Age (In yrs. last birthday,	If Under	1 Year Days	If Under a	24 Hrs. Min.	8. Date of	Birth Day Yo	ar) (
	Director		5//-14-/644	10 M 2U F	89 Yrs.	IVIOIILIS	Days	Tiours	WIII I.	8. Date of (Month Feb.	11,	1916	Nort	nce (State of h Car	olina
	land ow		Usual Residence of Decedent 10a. State 10b. County	1	IOc. City, Town or L	ocation						<u>.</u>	10	d. Inside Ci	ity Limits
	Man B-f sh	tor	Maryland Prince G	eorge's	Clinton									XXYes	2 🗆 No
	or 28	Direc	10e. Street and Number			10f. Zip (Code				10g.	Citizen of Wh	nat Countr	y?	
	s 23a	rall	7520 Surratts Roa									ited S			
	fter de ritem Iner	Fune	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ev Armed Forces?	1941 –	Was Decede If Yes, speci	ent of His ify Cubar	spanic Orig n, Mexican	gin? (Spe i, Puerto	ecify Yes or Rican, etc.	No-	14. Race - Black,	- America White, et		
036	al', o	by	3 Widowed 4 □ Divorced	1 XYes 2 No If Yes, Give Year or Dates:	1945	1 Yes 2	No K	Specify:				Specify:	B1a	ck	
5-0	within 72 hours after death with the Maryland she. than "natural", or items 23a or 28a-f show to Midical Examiner mat be multified at	Completed by Funeral Director	15. Decedent's Ed (Specify only highest gra	ducation de completed)	(Give	dent's Usual	k done di	urina most	of work	ina	16b	. Kind of Busi	iness/Indu	istry	
121	within ane. than	E E	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	e retired)	•							
d 2	filed Hygid other ent,	Be Co	17. Father's Name (First, Middle, Last)		11811	nanuı		18. Mothe	r's Name	e (First, Mic		overnm den Sumame)			
lan/	uld be Aental rked tic ev	To B	Wiley McMillan					C1e	opat	ra Ma	xwe1	1 Youn	Q		
Maryland 21215-0036	2 sholl and his ma	-	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address ((Street a					y or Town, St		Code)	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show among injury or other traumatic event, the Medical Examiner must be notified at once.		Miriam Maxwell Sa	inders/daugl	nter 311	0 Merr	yda]	le Dr	ive,	Uppe	r Ma	rlboro	, MD	207	72
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐	i iomorai moim otato	20b. Place of Dispo					Date		Location - Ci	•		
Ħ	mit. Pages bartment of cortant: If i injury or e	1	' 4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Licer		Marylan				5/19 Mc		Fun	urel, l eral S	Mary]	Land	
B	Depar Impo any ir	1 6	Cincles:	1 lams								hington			20012
	Pnysician /Medical Examiner	her	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	aProstat Due to (or as a c	consequence of):	er the mode	of dying	, such as o	cardiac c	or respirator	y arrest,		1	Approximate nterval Bety Onset and E	ween
68760,	death certificate be executed e attending physician and of for use as the burial-transit	edical Examiner	that initiated events resulting in death) Last	cDue to (or as a c	consequence of):										
.O. Box	it the death certification by the attending placehed for use as t	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1□Live birth 2[4□Pregnant at tim 9□Unknown	Fetal death 3	Ectopic pred					-	23d. Date of Month			'ear
Records, P.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions c	ontributing to death but r	not resulting in the u	nderlying cau	use giver	n in Part I.				o use contribu			
al Reco	The ate h page	Completed								24a. W au pe 1 🗆 Ye	utopsy erformed	prio dea	or to comp th?	y findings a lietion of ca	vailable use of
Vital	Physician: this certific al director,	o Be	25. Was case referred to medical examiner? 1 Yes 2X No	Hospital:	4EEE/0.		Other			Check on					
of	ding h. After funer	H ::	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	2 ER/Outpatier 28b. Time of Injury		c. Injury a	4 LZLIVUI	- 2			6 Other jury occurred			
Division	Pir Dir	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (eet, factory,	office		2	28f. Location City or	n (Street Town, Sta	and Number (ate)	or Rural F	Route Numb	er,
	To the Hospital within 24 hours a To the Funeral I completely filled	ledical	one)	ysician: To the best of n iner: On the basis of ex and manner stated	amination and/or in	occurred at vestigation, in	the time	, date and nion, death	i place, a h occurre	and due to t ed at the tim	he cause ne, date a	(s) and manning and place, and	er as state due to th	ed. le cause(s)	
	5 W T N	Σ	29b. Signature and title of certifier	(~.			License					ate signed (f		y, Year)	
1	oxl		30 Name and address of assessment	y ame	h (Itam 00=) CT		3520	J6			Ma	y 16,	2005		
			30. Name and address of person who of William T. Tanne:		n (Rem 23a) (Type, 701 Livin	,	Road	1, #1	01 F	it. Wa	chin	aton	MD	20744	
•	Sta , Registr		31. Date filed (Month, Day, Year) MAY 1 7 200		Signature form		2.00	- , " -	J.	C. Wa	SHIII	gron,	FID ,	20744	

		ı	For State Registrar		ryland / Der Ce	oartment o		and Me	ental Hy		005	18399
	Physici /Medic		1. Decedent's Name (First, Middle, Last Paulette A. Mor	rison					2. Date of De Month May 1	3, 200		3. Time of Death 7:31 A. M
	Examin Funeral		4a. Facility Name (If not institution, give Suburban Hospital 5. Social Security Number 6. Se		(In yrs. last birthda 76 Yrs.	Beth	wn, or Location Lesda Year If Under Days Hours		8. Date of Bin (Month, Da June 17	Mor	nty of Death	ry place (State or Foreign ntry)
	Director		Usual Residence of Decedent 10a. State 10b. County Maryland Montgomer		76 Yrs. 10c. City, Town or Garrett	_			June 17	, 1920		York 10d. Inside City Limits 1X Yes 2 □ No
	with the M te or 28e-f the notifie	Director	10e. Street and Number 10707 Shelley Cour			10f. Zip Co					of What Cou	-
920	72 hours after death with the Maryland naturel', or Items 23e or 28e-f show Jical Examiner is but be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		! B. Was Deceden If Yes, specify 1 ☐ Yes 2💢	nt of Hispanic Or Cuban, Mexica No Specify	n, Puerto P	cify Yes or No lican, etc.)		Race - Ameri Black, White ecify: Whi	, etc.
Maryland 21215-0036	within 72 ene. then "na	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		+) (Gi	redent's Usual C ve kind of work of DO NOT use	done during mos retired)	st of workin	g		of Business/Ir	•
/land	at Hyg	To Be C	17. Father's Name (First, Middle, Last) Ernest Joseph S	Slaney			Pau	line	(First, Middle, Ernes	tine	Knauf	
	es 1 and 2 should to fleath and Ment fitem 27 le market cother treumatic		19a. Informant's Name/Relationship (7) Mairi Morrison/ Da		1070	7 Shell	ey Cour	t, Ga	rrett	Park,N	1D 208	396
Baltimore,	permit. Pages 1 Department of H. Importent: If iter eny Injury or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ I '4 □ Onation 5 □ Other (Specify, 21. Signature of Funeral Service Licens)	20b. Place of Dis cemetery, c Geo. Was Medical	h. Univ Center	ersity	May 1		Washi	ngton,	
Ba	Deps Impo		23a. Part1. Enter the disease, or comp	5 ords			P.O.	Box 5	8007 W	ashing	gton, I	D.C. 20037
3760,	Physician / Medical Examiner physician and physician and physician	Ilcal Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. DVT/PE Due to (or as a Due to (or as a	a consequence of):							Interval Between Onset and Death
.O. Box 68	The law requires that the death certificat the has been signed by the attending phy cage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐Fetal death	B⊟Ectopic preg B⊟ Other (spec				23d	. Date of deliv Month	rery Day Year
<u>α</u>	w requires that been signed b should be dete	þ	Part II. Other significant conditions co	ntributing to death bu	ut not resulting in the	underlying cau	se given in Part	l. 				the cause of death?
Vital Records,		Completed							24a. Was autor perfo	rmed?	4b. Were autoprior to condeath? 1 ☐ Yes	opsy findings available ompletion of cause of
Vita	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Trinpatie	nt 2 ER/Outpat	ient 3□DOA	Other		(Check only only only only only only only only		Other (Speci	(v)
Division of	ing After une	-	27. Manner of Death 1X Natural 5 Pending investigation	28a. Date of Injur (Month, Day			Injury at Work?]No	8d. Describe I	now injury o	curred	
Divis		Certification:	4 Homicide determined	building, etc					City or To	vn, State)		al Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical	29a. Certifier Descripting Physics (Check only one) 2 Medical Example one)	rsician: To the best of iner: On the basis of and manner sta	of my knowledge, de examination and/or ited.	ath occurred at investigation, in	the time, date a my opinion, de	nd place, a ath occurre	nd due to the d at the time,	cause(s) and date and pla	d manner as a	stated. to the cause(s)
)	To the within 7 To the comp	Me	29b. Signature and title of certifier			Г	icense number 00061302				gned (Month, 13, 200	
			30. Name and address of person who of Atul Rohata, M.D.	8600 Old	Georgeto	wn Road	l, Bethe	sda,	MD 20	814		
	Sta Regist		31. Date filed (Month, Day, Year) MAY 1 7 200	5 Serve	ar's Signature	wh)						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** VO 50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SA 13 BUNY Index 1 Year If Under 24 Hrs. WICOMICO 7. Age (In ys. last birthday) Il Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours Min. 1**⊠**M 2□ F 88 Yrs. 216-18-8150 Director 11/29/1916 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show Department of Health and Mental Hygiene. Important: or Items 23a or 28a-f show important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, If a Nedical Exact in an inual be restitled at 1 ☐ Yes 2 🕅 No Maryland Wicomico Director Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 250 Dykes Rd 21804 USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1XYes 2 No 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: Army Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify white Specify: Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Dresser/Wayne Pump Elementary/Secondary (0-12) College (1-4or 5+) Inspector 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph J. McAllister Ida Mav Ruark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael L. McAllister/nephew 235 Dykes Rd., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Wicomico Memorial 4 □ Donation 5 □ Other (Specify) 5/17/05 Salisbury, MD 22. Name and Address of Facility HOLLOWAY Funeral Home Professional Association Signature of Funeral Service Licensee Holloway Funeral Home Profe
501 Snow Hill Rd., Salisbur
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ALGENSCHORD HI **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) the attending physician Box 68760 Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 4 Inknown 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funerel Director; the 6 Could not be determined 3 Suicide Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide Hospitel filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical npletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 32014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM S- 504 B SAPILBUM UND 2180 31. Date filed (Month, Day, Year) MAY 1 7 2005 Goods! Registrar

			1 - For State Registrar	State of Ma		d / Depa	artme		ealth and	d Me	ntal Hy	giene Reg. No	2005	1840
	Physici		Decedent's Name (First, Middle, Las Susan Carter	Megarge	e					2	Date of De Month	Day		3. Time of Death
Ļ	/Medio		4a. Facility Name (If not institution, give PUNUSU/A REGIONAL S. Social Security Number 6. Sec.	street and number) //////// ox 7. Age	1 00	infu ast birthday)	If Und	Sa.	Location of De	1		4c.	County of Dea	ath
1	Director		Usual Residence of Decedent	∃M 2XIF 7		Yrs.	Month	Days	Hours N	fin.	Date of Bir (Month, Da 9/23/	1927	Mar	yland
	e-f show	tor	Maryland Wicomic	co		Town or Lo								10d. Inside City Limi
and the second	3e or 28	al Direc	10e. Street and Number 511 Camden Ave.					ip Code 1801				-	izen of What C JSA	Country?
	the angle of the mainter of the control of the cont	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Narried 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1/20 If Yes, Give Year or Dates:				edent of Hi ecify Cuba 2 XNo	spanic Origin? n, Mexican, Pe Specify:	(Specifuerto Ric	y Yes or No an, etc.)	0-	14. Race - Am Black, Wh Specify: wh	
	e. an "netur Medical	npleted	15. Decedent's Ed (Specify only highest grade Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5	i+)	16a. Dece (Give life.	dent's Us kind of v DO NOT	ual Occupa vork done d use retired	ition luring most of)	working			ind of Busines	
3	ntal Hygiene ad other the	Be	12 17. Father's Name (First, Middle, Last) Orman Dallas Car	4		Tea	ache	r	18. Mother's				Educati Sumame)	on
	h and Mental 7 Is markad o traumatic eva	2	19a. Informant's Name/Relationship (7 Ann M. Palmer/dau	ype, Print)		[-		Mary Ind Number or St., P	Rurai F	Route Numb		or Town, State,	Zip Code)
6	nent of Heal ant: If itam 2 ary or othar		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	C+ Ce	ace of Disposemetery, cre- Andre	osition (A	ame of other plac Episc	opal 5	Date 5/18	9	20c. Lo	ocation - City o	r Town, State
	Departr Imports any inju		21. Signature of Funeral Service Ligen	ever (CP		HOLL 501	oway : Snow :	s of Facility Funeral Hill Ro	Ho	me Pro Salis	ofess	sional , MD 21	Associatio
	hysician /Medical Examiner	ler	23a. Part1. Enter the disease, or compshock, or heart failure. List only disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury		a consequ	ence of):		_	SENIC	_				Approximate Interval Between Onset and Death
	fire family divisor, that the death commute be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequ	uence of):								
1	ed by the attending phy detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal	death 3	⊒Ectopic ⊒ Other (pregnancy specify)					23d. Date of de Month	blivery Day Year
	n signed	by	Part II. Other significent conditions of	ontributing to death b	ut not resu	ulting in the u	inderlying	cause give	en in Part I.	_				to the cause of death? Probably 4 Unknow
		Completed								-	24a. Was auto perfo 1 Yes		prior to death?	
	this certificate	o Be	25. Was case reterred to medical examiner?	Hospital:	ent 2 🗆 E	ER/Outpatie	nt 3🗆 I	Othe	26. Place of				6 ☐Other (Sp	ecify)
3	eath. tor: After the fune	Certification: T	27. Manner of Death Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		y Year)	28b. Time o	М		at i? res 2 □ No		d. Describe			Rural Route Number,
	within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determined	28e. Place of Injubulding, etc	c. (Specify	")			ne, date and ni		City or To	wn, State)	
	nin 24 ho the Fun npletely	Medical	(Check only 2 Medicel Exem	niner: On the basis of and manner sta	f examinat	ion and/or in	vestigati	on, in my o	oinion, death o	ccurred	at the time,	date and	d place, and du	e to the cause(s)
i	Corn. With	×	29b. Signature and title of certifier	Jus				9c. License	6576	N.		29d. Da	te signed (Mon	ın, Uay, Year)
	Pa		30. Name and address of person who	Tono	INC	55	0	RNE	48 (DE	30)RIVE	-,5	ALLS.	MD 2180
	Sta Registi		31. Date filed (<i>Month, Day, Year</i>) MAY 1 7 2	005 32. Spistra	ar's Signat	ture	book							

		1	For State Registrar	State of M	laryland	•	artment of H rtificate of I			giene Reg. No	05	18402
	q		1. Decedent's Name (First, Middle, Last)						2. Date of De	eath Day	Year	3. Time of Death
	Physici /Medic		Marion Jones Mit	chell					May		2005	4:30 PM
4	Examir	er	4a. Facility Name (If not institution, give s				4b. City, Town, or				y of Death	ımdal
			Annapolis Nursing 5. Social Security Number 6. Sex			ast birthday)	If Under 1 Year	nnapoli If Under 24 Hr			ne Arı	
	Funeral Director			M 2XF	88	Yrs.	Months Days	Hours Mir	. (Month, Da	iy, _{Year)} 8, 1916		place (State or Foreign ntry) linois
	Maryland f show led at	tor	10a. State 10b. County Maryland Anne Aru	ndel	10c. City	, Town or Lo		napolis			1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	s with the	I Direc	10e. Street and Number 85 Mannesa Road				10f. Zip Code	214	01	10g. Citizen of	What Cour	
320	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or liems 23e or 28e-f show event, i're Medical Exam wenn in a collifie a at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 Tes 2 Tes If Yes, Give Year or Dates:	? No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2821No	ispanic Origin? (In, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	Speci	ce - Americack, White,	
215-0036	thin 72 hou e. an "natura Medical i	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or	5+)		dent's Usual Occup kind of work done o DO NOT use retired		orking	16b. Kind of E		
	filed with Hygiene ithar tha	S		4		H	omemaker		45. 44.44			wn Home
yland 2	d la b	To Be	17. Father's Name (First, Middle, Last) Almon Everett Jon	es, Sr.					on Beck	, Maiden Suma	me)	
Mary	id 2 should th and Mer 27 is marks treumatic		19a. Informant's Name/Relationship (Ty Richard Mitchell/s				ng Address (Street O Poplar		Rura <i>l R</i> oute Numb Annapol			
ē,	s 1 and if Health Itam 27 othar to		20a. Method of Disposition		20b. PI		osition (Name of matory or other place		Date	20c. Location		
Ê	0 0		1 ☐ Burial 2X Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			e Cremato	ory 5/	17/2005	Balti	more,	Maryland
Baltimore,	permit. Pag Department Important: t any injury o		21. Signature of Funeral Service Licens			1	2. Name and Addre					
F	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that cause ne cause on each	ed the death line.	Do not en	er the mode of dyin	ig, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
3/60,	death certificate be executed a attending physician and ad for use as the burial-transit	licai Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a Due to (or a Due to (or a	s a consequence a consequence	ience of):						
O. Box 68	the death certificate t the attending physic ched for use as the b	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcom 1□Live birth 4□Pregnant: 9□ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)	,		1	ate of deliver	ery Day Year
ds, F.	uires that the de signed by the a ld be detached f	d by Ph	Part II. Other significant conditions con	. 11	but not resu		nderlying cause giv	en in Part I.		tobacco use cor Yes 2 □ No	ntribute to th	ne cause of death? pably 4 Unknown
Vital Records,	Physician: The law requires that the rthis certificate has been signed by the raid director, page 2 should be detach	Completed by					-		24a. Was auto perfo 1 🗆 Yes		Were auto prior to con death? 1 Yes	psy findings available mpletion of cause of 2 No
VII	ician certific	Be	25. Was case referred to medical examiner?	lospital:			Oth	05	eath (Check only			
	ling Phys	ion: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of In (Month, D	jury	28b. Time o Injury	f 28c. Injur	y at	Home 5 Res	how injury occu		/)
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In	njury - At ho atc. (Specify	ome, farm, st	reet, factory, office		28f. Location (City or To	(Street and Num wn, State)	iber or Rura	al Route Number,
_	To the Hospital or Ati within 24 hours after of To the Funaral Diract completely filled in by	Medical Ce	29a. Certifier Check only one)	sicien: To the bes	of examinat	wledge, deat tion and/or in	h occurred at the til vestigation, in my o	me, date and pla	ce, and due to the curred at the time,	cause(s) and n date and place	nanner as st	lated. the cause(s)
	o the ithin 2 o the omple	Med	29b. Signature and title of contiler	and maillel	ALLEGOU.		29c. Licens	e number		29d. Date sign	ed (Month,	Day, Year)
	F 3 ⊢ 5						DE	5702	8	5/16	105	,
			30. Name and address of person who co	ompleted cause of	death (Item	23a) (Type,	Print) 1721	ANKIAT	bus, N			
	C+	ate	31. Date filed (Month, Day, Year)	32. F gis	trar's Signa	ture,	V. KFN	1710117	VU-, IV	IN PITT	<u></u>	
*;	Regist		MAY 162	005	the .	A A	South					

		•	1- State Registrar AMEND ITEM #10e PER FH G8/4		Reg	1. No. 2 UU5 18403
ı	Physici		Decedent's Name (First, Middle, Last) Charles Markey		2. Date of Death Month May	Day Year 12, 2005 8:50 p M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Chesapeake Hospice House	Linthicum		Anne Arundel
ŀ	Funeral Director		5. Social Security Number 190-05-9930 19	Months Days Hours Min	8. Date of Birth (Month, Day, Y Jul. 13	
	Maryland a-f show	ctor	10a. State 10b. County 10c. City, Town of MD Anne Arundel	r Location Pasadena		10d. Inside City Limits 1 □ Yes 2 ⊠No
	h with the 23e or 28	Funeral Director	100 Street and Number 3231 Elvaton Drive	10f. Zip Code 21122	100	g. Citizen of What Country? USA
036	be filed within 72 hours after death with the Maryland and Hygiene. And Hygiene. And other then "neturel", or items 23e or 28e-f show event, the Medical Examiner must be motified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: WWII	13. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2 ☑ No Specify:	cify Yes or No- lican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	e filed within 72 hc al Hygiene. I other then "netui vent, I'n Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ecedent's Usual Occupation live kind of work done during most of workin le. DO NOT use retired) Plasterer	g 16	Construction
/land	should be filed and Mental Hygis s marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) William Markey	18. Mother's Name Ethel Coo		aiden Sumame)
_	and 2 sho alth and h	•		ailing Address (Street and Number or Rural B Ashton Road, Ashtor		City or Town, State, Zip Code) 0861
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ments Importent: If Item 27 is marked eny injury or other treumatic e once.		1 Removal from State	isposition (Name of crematory or other place) erans Cemetery May 20		oc. Location - City or Town, State Crownsville, MD
Bair	permit. Departrimporte eny inju		21. Signature of Furreral Service Licensee	Barranco & Sons, P.1 495 Gov. Ritchie Hw	A. Sever	na Park Funeral Home na Park, MD 21146
	Physician /Medical Examiner	her	23a. Part. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	419		t, Approximate Interval Between Onset and Death
. Box 68/60,	death certificate be executed e attending physician and d for use as the buriat-transit	Physician/Medicai Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
s, P.O	the by th	by Phys	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		cco use contribute to the cause of death?
al Records,	The law ate has b page 2 s	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of
ion of Vital	Attending Physicien: Thr death. ector: After this certificate by the funeral director, pag	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpa 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 1 Inpatient 2 EP/Outpa 28b. Time (Month, Day Year)	e of 28c. Injury at 2		7 9
Division	iel or Atte s after dei al Director ad in by th	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	8f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	edicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, of the desired physician of the desir	eath occurred at the time, date and place, as ir investigation, in my opinion, death occurre	d at the time, date	e and place, and due to the cause(s)
	To t Withi To th	X	29b. Signature and title of certifier	29c. License number		1. Date signed (Month, Day, Year)
			30. Name, and address of person who completed cause of death (Item 23a) (Ty	pe, Print) 7845 Oc	atwo	10y13th 2005 od Rd. #103
· **	Sta Registr		31. Date filed (Month, Day, Year) 32. Restar's Signature AV 1 7 2005	And		

	-	For Stete Registrar	State of Maryland	-	artment of rtificate of		F	leg. No.	05	1840
Physicia /Medic		1. Decedent's Name (First, Middle, Last Ethelyn S. Meches:	ney		T = =		2. Date of Dea Month May	14, 2	Year 2005	3. Time of Death 7:30 a
Examine Funeral		4a. Facility Name (If not institution, give 43 W. McKinsey Ro. 5. Social Security Number 6. Se	ad, Apt. 105				rk rs. 8. Date of Birti	Year)	e Ar	undel
Director		215-48-241	93	Yrs.			Mar. 4	, 1912	11	PA Od. Inside City Limit
ith the Mar or 28a-f sh e notified	Director	MD Anne Art			10f. Zip Code	verna Par		10g. Citizen of W		1 □ Yes 2 🖔 N try?
permit. Pages 1 and 2 had be filed within 72 hours after death with the Maryland permit. Pages 1 and Paland Department of Health and Mental Hygiene. Important: if I tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avant, the Medical Evantral must be notified at once.	d by Funeral Director	43 W. McKinsey Ro	12. Was Decedent Ever in U.s Armed Forces? 1 ☐ Yes 2 🎛 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No	Specify:	(Specify Yes or No- erto Rican, etc.)	Specify:	- Americ k, White, k	ite
ad within 72 hours aft gjene. ar than "naturai", or i, I're Medical Evani	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		16a. Dece (Give life.	dent's Usual Occi kind of work don DO NOT use retir	e during most of w ed)	vorking	16b. Kind of Bu	siness/Ind Home	•
d 2 should be filed the and Mental Hygis is marked othar traumatic avant, it	To Be Co	17. Father's Name (First, Middle, Last) A. Camp Streamer	4		TOTAL	18. Mother's N	ame (First, Middle, Ethelyn (Maiden Surname	9)	
permit. Pages 1 and 2 should be shou		19a. Informant's Name/Relationship (T Charlotte M. Sim					Rural Route Numbe et, Wilmi			Code) 9806
Pages 1 a nent of He ent; if item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify	Removal from State	emetery, cre	position (Name of matory or other pi crematory	Mace) Ma	ay 17, 2005	Baltimo		
permit. Departr Importa any inje		21. Signature of Funeral Service Licent	1620m5	B:	Name and Add arranco de 16 Gov.	Ritchie	P.A. Seven	rna Park rna Park	Fun	21146
Physician /Medical		234. Part1 Enter the disease, or common short, or heart failure. List only common late Cause (Final Lase or condition resulting in death)	ications that caused the death ine cause on each line. a A L Z HE I Due to (or as a consequ	MER			iac or respiratory ar	rest,	3.n.— 54	Approximate Interval Between Onset and Death 3
Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cause of Hiju.) that initiated events	b. Due to (or as a consequ	ence of):					+	/
eath certificate be executed attending physician and for use as the burial-transit	icai	resulting in death) Last	Due to (or as a consequent)	ience of):						
Q 0 Q	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	□Ectopic pregnan □ Other (specify)	су		23d. Date Mor	of delive	ry Day Year
w requires that the been signed by the should be detache	d by Ph	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the u	ınderlying cause g	oven in Part I.	23e. Did to	- 1		e cause of death? ably 4 □Unknow
e ia has	Completed by							sy p med? d	rior to cor eath?	osy findings availat npletion of cause of 22 No
ysician: is certific director.	To Be (25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	Hospital: 1 Inpatient 2	-	III 3 DOA	ther: 4 Nursing	eath (Check only o	ence 6 Othe		')
ding After fune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time (M 11	_Yes 2 □No		ow injury occurre		I Pauta Number
Hospital or At 4 hours after of Funarai Dirac tely filled in by		4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	') 			City or Tow	n, State)		
To the Hospital or Attant within 24 hours after death To tha Funarai Diractor: completely filled in by the	Medical	(Check only 2 Medical Exernance) 29b. Signature and title of certifier Bughtt 2	iner: On the basis of examinat and manner stated.	tion and/or in	29c. Lice	opinion, death or	ccurred at the time,	29d. Date signed	(Month,	Day, Year)
	te	30. Name and address of person who of BIPGITTH & MILL 31. Date filed (Month, Day, Year)	completed cause of death (Item E12 2003 M 33 Registrar's Signa	23a) (Type EDICA	Print) L PARK U	VAY ShITE	=100 AN	NAPOLIS	MD	21401

			1- For State of Maryland / Registrar	Dep		Health a		ital Hygie		Jie.	18405
П	Physici	an	Decedent's Name (First, Middle, Last)					Date of Death Month	Day	Year	3. Time of Death
I	/Medi		Ruth C. McMahon					May 14,	^{Day} 2005	1041	8:30 A M
	Examir	ięr	4a. Facility Name (If not institution, give street and number)		4b. City, Town,		Death		4c. County		
Ŀ			812 Coxswain Way 5. Social Security Number 6. Sex 7. Age (In yrs. last b	irth day)	If Under 1 Yea	polis	4 Hrs lor	Data of Birth	Anne A		
	Funeral Director		089–10–1516 Usual Residence of Decedent	Yrs.	Months Days		Min.	Date of Birth Month, Day, Y 0-7-19	16	9. Birthp Cour. New	place (State or Foreign htry) York
	72 hours after death with the Maryland 'neturel', or Items 23s or 28s-1 show dical Examinar institute notified at		10a. State 10b. County 10c. City, Tot	wn or Lo	ocation					1	0d. Inside City Limits
	e Mai	ctor	Maryland Anne Arundel A	nnar	polis						1 ☐ Yes 2 No
	ith th	by Funeral Director	10e. Street and Number		10f. Zip Code			10g	. Citizen of W	hat Coun	itry?
	ath w	ral	812 Coxswain Way		21401				USA	<u> </u>	
	ter de Items	une	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces?	13.	Was Decedent of If Yes, specify Cul	Hispanic Origi ban, Mexican,	n? (Specify Puerto Rica	Yes or No- n, etc.)		- Americ , White,	an Indian, etc.
39	urs af	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 9		1 ☐ Yes 2 No	Specify:			Specify:	Wh:	ite
Ŏ	2 ho	ted	15. Decedent's Education 16a	a. Dece	dent's Usual Occu	pation		16	b. Kind of Bus	siness/Inc	dustry
7	thin 7	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life.	kind of work done DO NOT use retire	ed) auring most o	of working				
2	led w lygier her th	Co	12th		Homemake				Home		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: It item 27 is marked other then "neturel", or Items 23s or 28a-1 show any injury or other treumatic event, the Modical Examinational Legical and once.	To Be	17. Father's Name (First, Middle, Last) James Walsh				,	_{st, Middle, Ma} beth Gi		9)	
lar.	2 sho and Is ma				ng Address (Stree						Code)
	l and tealth im 27				Lavall (
Baltimore,	ages nt of h		TEDUTE E CONTRACTOR S ENGINEERING STATE		nsition (Name of matory or other pla		Date		c. Location - (
	iit. Partmei artmei ortent injury		4 Donation 5 □ Other (Specify) Holy 21. Signature of Funeral Service Licensee		d Cemete	_	-18 - 05		estbur		
eg Ba	Depa Impo any ir		> /Mut Ville	2	2. Name and Addr 2973 Solo	omons I	sland	Rd. Ed	lgewate		
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PNEUMONIA Due to (or as a consequence of any, leading to immediate	of):	MULT 1			piratory arrest			Approximate Interval Between Onset and Death
68/60,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence c. Due to (or as a consequence d. Due to (or as a consequence d.								
P.O. Box	the death certific by the attending p ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ♣ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnanc	у			23d. Date Mont		ry Day Year
	sign d be	þ	Part II. Other significant conditions contributing to death but not resulting	in the ur	nderlying cause gr	ven in Part I.		23e. Did tobac 1 ☐ Yes			e cause of death?
records,		Completed				····		24a. Was an autopsy performed	pri		sy findings available apletion of cause of
VIII	ysician: The is certificate ha director, page	Be C	25. Was case referred to medical examiner?			26. Place of		eck only one)			
on or	무 등 표	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ EP/Oi 27. Manner of Death 28a. Date of Injury 28b.	utpatien Time of Injury	28c. Inju		28d. ī	5 Residence Describe how i)
DIVISION OF	Hospital or Attending I 24 hours after death. Funeral Director: After tely filled in by the funer	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, stre			28f. L	ocation (Stree City or Town, S		or Rural	Route Number,
	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in b.	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge 2 Medical Examiner: On the basis of examination are and manner stated.	e, death	occurred at the ti	me, date and popinion, death	place, and d occurred at	ue to the cause the time, date	e(s) and manr and place, an	ner as sta d due to	ited. the cause(s)
	To t Com	Σ	29b. Signature and title of certifier		29c. Licens	se number		29d.	Date signed	Month, D	ay, Year)
			Brie 2 Wood MD		0 00	x 617=	76		5/14/	2005	~~ 3
			30. Name and address of person who completed cause of death (Item 23a)		•						
			BRIAN E WOLF MD, 116 DEFENSE 31. Date filed (Month, Day, Year) 32. Megistrar's Signature	416	tway, 50	TE 400	O, ANI	VAPOLIS	s, MAR	CANY.	D 21401
D gé	Sta Registra		31. Date filed (Month, Day, Year) 32. egistrar's Signature		Milly.						

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

					St	ate of N	naryland	•	partmei Prtifica			i Mentai H	ygien: Reg. N	00	05	18406
	Dhusisi	q.1	1. Decedent's Name	First, Midd	le, Last)							2. Date of D	eeth	ay	Year	3. Time of Death
	Physicia /Medic			ames G								May 5	, 20	005	311	10:35 am
ч	Examin	er	4a Fecility Name (II			t end numbe	r)			4	46. City, Town, o	or Location of Dee	etn 40	c. County	tgom:	0.277
	.		5. Social Security N	Manor	6. Sex	7. /	Age (In yrs. <u>k</u>	st birthday		er 1 Year	if Under 24 H	rs. 8. Date of B	irth			el y elace (State or Foreign etry)
	Funeral Director		722.05.2		1 🛣 M		7	7 Yrs.	Months	Days	Hours Mi	Dec.	7, 19	27	Penn	sylvania
	pu >		Usuel Residence of 10a. State	Decedent 10b. County			10c City	, Town or I	Location						1	0d. Inside City Limits
	shov	5														YXYes 2 □ No
	28a-1	ect	MD 10e. Street end Nun		gomery	7		Bethe		ip Code			10g. C	itizen of W	hat Cour	itry?
	3a or	Funeral Director	7601 Hon		av					2	20817			U.S	.A.	
	death	ner	11. Marital Status		12. V	Vas Deceder	nt Ever in U,S	S. 13	. Was Dece	edent of H	lispanic Origin?	(Specify Yes or North Property (Specify Yes or North Property)	lo-		- Americ	an Indien,
21215-0020	filed within 72 hours after death with the Maryland Hygiena. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	by Fu	1 ☐ Never Marri 3 ☐ Widowed		ried 1	∑XYes 2 ☐ iYes, Give ⁄ear or Dates	No WW	II	1 ☐ Yes		Specify:	one mount ore.		Specify:		hite
5-0	72 h	etec	(Spec	15. Deceder	it's Education st grede con	n n <i>pl</i> eted)		16e. Dec (Giv	edent's Usi e kind of w	ork done	ation during most of w d)	vorking	16b. I	Kind of Bu	siness/Ind	dustry
121	within the sna.	Completed by	Elementary/Secon	ndery (0-12)	C	College (1-4o	r 5+)		iter/1				Co	meu1	tina	Company
d 2	Hygie ther ont,	ပို့	17. Father's Name (First, Middle,	Last)		1	WLJ	LLCI/I			ame (First, Middi				Company
lan	lid be ked c	To Be	James	Ingna	tius N	No1an					M	largaret	Syry	1 Ha	ggar	ty
Maryland	should be man		19a. Informant's Na	me/Relations	ship <i>(Type, P</i>	Print)		19b. Mei	iling Addres	s (Street	and Number or	Rural Route Num	ber, City	or Town, S	State, Zip	Code)
Σ.	and 2 n 27 i		Joan Nol		fe						lay Bet	hesda, N			208	
Baltimore,	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Haalth and Mantal Hygiena. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at pince.		20a. Method of Disp 1 A Burial 2 Donation	Cremation		val from Stat	Ce	metery, cre :e of	nosition (Na emetory or Heave	other place en		5/9/05 Joseph (Si1		Spri	ng, MD
Balt	parmit. Departimport. any Inj		21. Signature of Fu	meral Service	Licensee			2	22. Name a 5130 \	nd Addre	33 OF FACILITY	enue NW		200		, 1110.
	W 1.78	\exists	23a. Parti. Enter the	ne disease, or t failure. List	complicatio only one ca	ns that caus use on eech	ed the death. line.	Do not er	nter the mo	de of dyin	ng, such as card	iac or respiratory	arrest,		i	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (I	Final			.4 1		. 0						1	Offset and Death
À	Examiner		disease or condition resulting in death)		a				equence of		men.	hia-			I I	
		ner					Due to (or	es e conse	squerice or,	,.						
	icate ba executed physician and s the bunal-transit	Examiner	Sequentially list cor	nditions,	b		Due to (or	as e conse	equence of	:						
60,	ba exa ician g burial		Sequentially list cor if eny, leeding to im cause. Enter Under Cause (Disease or i that initiated events	mediate rlying injury	C											
68760,	phys s the	edical	that initiated events resulting in death) L	.ast			Due to (or	as a conse	equence of)	:					1	
Box (nding use a				d											
ω.	daath e atta ed for	SCIB	Part II. Other signifi	cant condition	ons contribut	ting to death	but not resul	ting in the	underlying	cause giv	en in Part I.	23b. Die	tobacco	o use con	tribute to	the ceuse of death?
P.O.	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be datached for use as the bunal-transit	Physician/N										10	Yes 2	2□ No	3 ☐ Prot	pably 4 Unknown
of Vital Records,	signe d be d	à								_		24a Wa	s an auto	nsv	24b. We	ere autopsy findings
Sor	requ been shoul	et e										per	formed?	,	cor	ailable prior to mpletion of cause death?
Re	he lav e has age 2	Completed										100	Yes 2	She	_]Yes 2⊠No
ta	an: T tificat tor, pa	Be .	25. Was case referr	ed to medica							26. Place of D	eath (Check only				
Ž	die Gie	2	examiner? 1 ☐ Yes 2 ☐	No	Hospit	tal: 1 ☐ Inpat	tient 2 🗆 E	R/Outpatie			4/CJ Nursing	Home 5 ☐ Res	idence	6 □Othe	r <i>(Specif</i>)	0
0	fter thunera		27. Menner of Death	5 Pendir		a. Date of In (Month, D	jury ley Year)	28b. Time Injury		28c. Injury Work		28d. Describe	how inju	iry occurre	ed	
Sio	death death for: A	Cat	2 ☐ Accident 3 ☐ Suicide	investi 6 ☐ Could	not be	se. Place of the	niunr - At hon	no farm s	M treet lacto		Yes 2□No	28f Location	(Street a	nd Numbe	r or Rura	I Route Number,
Division	after after Direction by	Certification:	4 ☐ Homicide	determ	nined 20	building,	etc. (Specify)	ile, iaitii, s	tioot, iacto	ry, onice		City or To	wn, State	е)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
_	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	edical C	29a. Certifier (Check only one)	Certifyir 2 Medical	Examiner: 0	n: To the bes On the besis	of examination	ledge, dea on and/or i	th occurred	at the tin	ne, date and ple- pinion, death oc	ce, and due to the curred at the time	e cause(s , date an	and mar d place, a	ner as st nd due to	ated. the cause(s)
	To the within Fo the complex		29b. Signature end	title of certifie					29	c. Licens	e number			. 1		Day, Year)
	6			pe)				I	0005	54566		5/6	0/05	•	
	Ψ	-	30. Name end eddre						, Print)	-						
			Suniva		avilli	122	0 A 20	sert:	20 66	aR	oad, s	ceih 2	30,	10 W	Nozo	,71021286
	Stat Registra	100	31. Dete filed (Month		2005	San Hegis	trer's Signatu	GOS.	II)							

DHMH 16 Rev 6/95

Registrar

MAY 1 8 2005

• .			•
State of Mar	ryland / Department	of Health and N	Mental Hygiene

			For State Registrar		State o	of Mary	/land /				lealth a D <i>eath</i>	ind M	ental Hy	giene				
	Physici		Decedent's Name (First, Mid John				01:	son					2. Date of De Month May 15,	ath Day	. UU5		3. Time of Death 5:53 a M	_
	/Medic Examin		4a. Facility Name (If not institut		reet and nu	ımber)					Location of		12,9 13,		County of De		-	_
	Funeral Director		4823 Ertter Dri 5. Social Security Number 349–20–3732	6. Sex	M 2□F	7. Age (Ir	74	birthday) Yrs.		ckvil er 1 Year s Days		Min	8. Date of Bir (Month, Da Nov. 8,	v Year)	9. B	irthpla Count	ace (State or Foreign ny)	
	show	٥٢	Usual Residence of Decedent 10a. State 10b. Coun Maryland		gomery	10		own or Loc Rockvi								10	d. Inside City Limits 1 ☐ Yes 2 ☐ No	_
	a with the N 3a or 28a-f	I Director	10e. Street and Number 4823 Ertter Dri		gonery			WCKV1		Zip Code 20852				10g. Citi	izen of What (Count	ry?	-
036	permit. Pages 1 end 2 should be filed within 72 hours eiter deeth with the Maryland Depertment of Heelih end Mentel Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any figury or other traumatic event. Its Madical Exeminat must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2X M 3 Widowed 4 Divorce	arried	2. Was Dec Armed F 1 DYYes If Yes, G Year or I	cedent Eve orces? 2 No ive Kore Dates: Col		13. V		edent of H ecify Cuba 2X No	ispanic Orig in, Mexican, Specify:	in? (Spe Puerto I	cify Yes or No Rican, etc.))-	14. Race - An Black, Wh Specify: Wh	ite, e		
21215-0036	within 72 ho ene. than "natur	Completed	15. Deced (Specify only high Elementary/Secondary (0-12	- T	ation completed,		2	6a. Deced (Give life. L	ent's Us kind of v DO NOT	vork done i use retired	ation during most noinee		ng		ind of Busines			
Maryland 2	uld be filed fentel Hygi rked other ilc event.	To Be Co	17. Father's Name (First, Middle Wendell E. Olson								18. Mother	r's Name	(First, Middle Hassett					_
, Mary	and 2 should be		19a. Informant's Name/Relation Betty U. Olson/		e, Print)		10.7		•	•			/Route Numb		r Town, State, 1852	Zip (Code)	
altimore,	Pages 1 (ment of He ent: If Iten ury or oth		20a. Method of Disposition 1 □ Burial 2 ☒ Crematio 4 □ Donation 5 □ Other		moval from	State	ceme	e of Dispos etery, crem polita	natory of	r other plac		May 2 2005	ate 20,		cation - City o			
Balt	permit. Depert Import any Inj		21. Signature of Funeral Servi	So	rel	0		50	O Uni	versit	y Blvd	, W,		pring	, MID 2090	-		
4	Fnysician		23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)	or complic st only one a.		caused the each line. static					g, such as c	cardiac o	r respiratory a	rrest,			Approximate Interval Between Onset and Death	
	/Medical Examiner	-	Sequentially list conditions,	Ь.	Coro	orasaconary An	rtery	Disea	se									
	xecuted n end al-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С.	Atria	al Fib	rillat	ion								_		
68760,	ficate be executed physicien end is the burial-transit	edical		d.	Hype	rtensi	ve Hea	art Di:	sease									
P.O. Box	the deeth certifi y the ettending Iched for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23		birth 2 [nant at tim	Fetal de	ath 3□		pregnancy specify)				:	23d. Date of d Month		y Day Year	
	law requires that the de es been signed by the e 2 should be detached f	by	Part II. Other significant cond	tions cont	ributing to o	death but n	ot resultin	ng in the ur	nderlying	cause giv	en in Part I.						bly 4XUnknown	
Il Records,	The ste h page	Completed				-							24a. Was auto perfo 1 \(\text{Yes}	psy	prior to	com	sy findings available pletion of cause of	
f Vital	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medi examiner? 1 ☐ Yes 2 ♣ No			Inpatient	2□ER/	/Outpatien	t 3 🗆 [Oth Oth			(Check only only only one 5 🔼 Resi		6 ☐Other (Sp	ecify)		
Division of	ding h. After fune	ertification;	Z Accident	stigation	28a. Date (Mor	of Injury nth, Day Ye	28 ear)	b. Time of Injury	М	28c. Injun Wor 1 🗆	yat k? Yes 2 □ N	No.	28d. Describe					
D	i grad	O	4 ☐ Homicide dete	mined	build	e of Injury ding, etc. (S	Specify)						City or To	wn, State)		Route Number,	13
	To the Hospital within 24 hours e To the Funeral I completely filled	edical	(Check only 2 Medic	al Examin	er: On the I		amination							date and	and manner and du	of et	the cause(s)	
		Σ	29b. Signature and title of certification of the control of the certification of the certific		V.	Posi	nh		2	9c. Licens	D47330	0			16, 20	nth, D	ay, Year)	
	10		30. Name and address of personant V. Jose							?ockvi]	le, Mar	rylan	d 20852					
ľ	Sta Registr		31. Date filed (Month, Day, Ye MAY 1		32.	degistrar's	Signature			2.0			-					-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are	e Legible
--	-----------

			1 - For State Registrar	State of Maryl		artment of rtificate of			iene eg. No.2005	18409
	Dhusia	-	1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea	th	3. Time of Death
	Physic /Medi		Marion J.	Owens - Bro	ooks			May	16 2005	9:04A M
7	Examir	ner	4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Dea	ath /	4c. County of Dea	th
			Doctor's Community 5. Social Security Number 6. Se		and the think to be	Lan			Prince Ge	
	Funeral Director		-	M 213 F 82	vrs. last birthday) Yrs.	Months Days		8. Date of Birth (Month, Day,	Year 1923 9. Bir	thplace (State or Foreign ountry)
			Usual Residence of Decedent	02		L		Februar	y l Oh:	LO
	72 hours after death with the Maryland netural', or Items 23e or 28e-1 show illeal Exarrainer must be notified at		10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	n the Marylar r 28e-f show	Director	NY Monroe		Rocheste	er				1 ves 2 No
	ith the	Jire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	ountry?
	ath w 23e	rai	138 Lozier Street			14611	l		U.S.A.	
	r deg	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of	Hispanic Origin? (Specify Yes or No- into Rican, etc.)	14. Race - Ame Black, Whit	
36	s afte	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🐼 No If Yes, Give		1 ☐ Yes 2 ☑ No		, , , ,		lack
21215-0036	hour tural		3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Edi	Year or Dates:	16a Daga	de ette Heuri Ossa				
15	in 72 n "ne	Completed	(Specify only highest grad	de completed)	(Give	dent's Usual Occu kind of work done DO NOT use retin	e during most of w	orking	16b. Kind of Business	Industry
212	with with r the	mo	Elementary/Secondary (0-12)	College (1-4or 5+) 2 yrs		acher	/		Governme	nt
	othe	Be C	17. Father's Name (First, Middle, Last)	2 113	, 10	acres	18. Mother's Na	ame (First, Middle, M		110
<u>a</u>	Aenta Aenta Treed	To B	Charles Owens				Marie	C. Thomp	son	
Maryland	should have		19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mailir	ng Address (Stree	at and Number or F	Rural Route Number	City or Town, State,	Zip Code)
	and 2 palth n 27 i		Elizabeth Brooks-C	Cooper/Dtr.	4 Sta	ten Driv	ve Upper	Marlboro,	Maryland	20774
ore	of He	1 3	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I	Pomoval from State	 b. Place of Dispo cemetery, crer 	sition (Name of natory or other pla	ace)	Date	20c. Location - City or	Town, State
Ē	Pag ment ent: l		`4 □ Donation — 6 □ Other (Specify,) W	hite Hav	ven Ceme	tery 5/23	3/05	Perinton, N	ew York
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Importent: If tem 27 is marked other then "netural; or items 23e or any injury or other treumatic event, I'm Medical Examinational to 2006.		21. Signatule of Pageral Service via	00	22	. Name and Addr	ress of Facility J	. B. Jenk	ins Funer	al Home
	40 E 3 G			8					r, Marylan	d 20785
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only or	lications that caused the d ne cause on each line.	eath. Do not ent	er the mode of dy	ing, such as cardia	ac or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. Sepsis						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con-						
		-	Sequentially list conditions,	b. Electro Due to (or as a cons	lyte Imb	palance				
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Congesti		t Foilur	0			
Ć,	execu n and ial-tra	Exai	that initiated events resulting in death) Last	Due to (or as a cons		c rarrar				
8760,	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burlat-transit	call		d						
9	tificate g phys as the	Physician/Medical		V						
Вох	leath certifica attending ph ifor use as th	In/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre 1□Live birth 2□F		1			23d. Date of del	ivery
	ne deat the att hed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time of]Ectopic pregnand] Other (specify) _			Month	Day Year
P.0	that the d ed by the detached	hy	9 Unknown							
	signed l	by	Part II. Other significant conditions co	ntributing to death but not	resulting in the ur	nderlying cause gi	iven in Part I.		acco use contribute to	the cause of death?
ord	w requir been si should	ted	Hypertension				·	1 □ Ye	s 2] ZNo 3∏Pr	obabiy 4 Unknown
Vital Records,	e taw has b	Completed	Chronic Obstruc	ctive Pulmon	ary Dise	ase		24a. Was ar autopsy	/ prior to d	topsy findings available completion of cause of
al F	Th ate pag	S.	Dementia					perform 1 ☐ Yes 2		2 ₹ No
Vit	Physicien: The this certificate all director, pag	00	25. Was case referred to medical examiner?	Hospital:		0	K	ath (Check only one		
of	Phys this ral dii	. To	1 Yes 2 X No 27. Manner of Death	1 ☑ Inpatient 2 28a. Date of Injury	ER/Outpatien 28b. Time of	1 3 DUA			nce 6 Other (Spec	cify)
on	ding Ph h. After th funeral	tion	1 ☑Natural 5 ☐ Pending	(Month, Day Year) Injury	28c. Inju Wo M 1	ork?]Yes 2 □ No	28d. Describe hor	w injury occurred	
Division	or Attending I after death. Director: After in by the funer	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - A	t home, farm, stre			28f. Location (Str	eet and Number or Ru	ral Route Number
á	after Direct of in by	Certification:	4 Homicide determined	building, etc. (Spe	ecify)	,,,		City or Town,		, and the state of
	To the Hospitel or Attenwithin 24 hours after deati To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying Phy	sician: To the best of my l	knowledge, death	occurred at the ti	ime, date and plac	e, and due to the ca	use(s) and manner as	stated.
	he Hi in 24 he Fi	edicai	(Check only 2 Medical Exami	ner: On the basis of exam and manner stated.	ination and/or inv	restigation, in my	opinion, death occ	urred at the time, da	te and place, and due	to the cause(s)
	To the within 2 To the complet		29b. Signature and title of certifier	/ taren	Un	29c. Licen:	se number	2/2 29	d. Date signed (Month	n, Day, Year)
			Jarnay	/ Jevone	nous /	WO	(1) S	40	7/16/)
P	(3)		30. Name and address of person who	ent leted cause of eath (I	tem 23a) (Type, I	PHO! EYN	1 05%	11-11)	110
1			31. Date filed (Month, Day, Year)	17/1/1/	1 UVL	1.510	1 8J A	U. NEW	AR LUIL TON	100 20784
9	Sta Registr		MAY 1 8 2005	3. Registrar's Sig	K Spar	دنگ				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items 4a, 28f per me 2844 6-1-05 vt

sician					Certificate of	Dealli		Reg. No. 🛴	UHB	181.1
	1.	Decedent's Name (First, Middle	, Last)				2. Date of De Month		Year	3. Time of Death
edical	_			Riall			May	23 23	2005	1:00 A
miner	4a	. Fecility Name (If not institution	, give street and number;)		r Location of Deat	h	1	ounty of Death	
al	5	6055 Seamore I		ge (In yrs. last birth		nsburg	R Data of Rin		icomico	
	٥.	214-46-2673	1 32 M 2□ F		rs. Months Days	Hours Min.	(Month, Da	y, Year)	1 -	lace (State or Fore try)
	Ü	sual Residence of Decedent		30			6/16/1	946	Mary	Land
_	1	a. State 10b. County		10c. City, Town	or Location				10	0d. Inside City Limi
Director	M	Maryland Wicom	ico	Parson	sburg					1 ☐ Yes 21X1
Sire	10	e. Street and Number			10f. Zip Code			10g. Citízei	n of What Coun	try?
		6055 Seymore L			2184			USA		
by Funeral	. 11	. Marital Status 1 □ Never Married 2 🗷 Marri 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	?	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No to Rican, etc.)		Race - America Black, White, a pecify: wh	
ed	-	15. Decedent	's Education	16a. [Decedent's Usual Occup	ation		16b. Kind	of Business/Ind	lustry
pier	-	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4or	(Give kind of work done life. DO NOT use retired	during most of word)	rking			,
Completed		12	4+	E	Clectrical H	Ingineer		Cons	sulting	
BeC	17	. Father's Name (First, Middle, I	Last)			18. Mother's Nar	me (First, Middle,	Maiden Su	mame)	
To		Albert G. Rial	1			Mattie	S. Shr	oyer		
		9a. Informant's Name/Relationsh	1 1 21 1	_	Mailing Address (Street			-		
	_	Margaret W. Ri	all/wlie		055 Seymore	e Lane, F				
	20	a. Method of Disposition 1 ☑Burial 2 ☐ Cremation	3 ☐Removal from State	20b. Place of the cemetery	Disposition (Name of Crematory or other place DILL Memory	(a)	Date	20c. Loca	tion - City or Tox	wn, State
		* 4 ☐ Donation 5 ☐ Other (Sp	A	Garden	S	5/2	28/05		oron, MI	
To Be Completed by Funeral Director	2	Signature of Funeral Service I	Fer ee	200	22. Name and Addre	ss of Facility Funeral	Home Pro	ofessi	onal As	sociatio
	1	pour of	mey (FJ0-	501 Snow	Hill Rd.	, Salish	oury,	MD 2180)4
	-	 Part1. Enter the disease, or shock, or heart failure. List 	only one cause on each i	ine.	ot enter the mode of dylr	ig, such as cardiad	or respiratory ai	rrest,		Approximate Interval Between Onset and Death
	d	nmediate Cause (Final isease or condition	Multio	E IN	uries					Onset and Death
	re	sulting in death)	Due to (or s	a consequence						
_	0									
	3	equentially list conditions,	b		7/4 3.					
Ę	if	any, leading to immediate ause. Enter Underlying	b	a consequence of):					
xamine	if GO th	equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last	c							
ai Examine	if Ga	any, leading to immediate suse. Enter Underlying ause (Disease or injury at initiated events	c	s a consequence of						
edicai Examiner	if Ga	any, leading to immediate suse. Enter Underlying ause (Disease or injury at initiated events	c							
edicai	if car	any, leading to immediate suse. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last	c	s a consequence of				230	I Date of deliver	DV.
edicai	if car	any, leading to immediate use. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last FEMALE: Bb. Was decedent pregnant in the past 12 months?	c	s a consequence of): 3□Ectopic pregnancy	,		23d	I. Date of deliver Month I	ry Day Year
edicai	if car	any, leading to immediate ause. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last FEMALE: 3b. Was decedent pregnant	c	s a consequence of):	,		23d		•
Physician/Medical	if car C th re	any, leading to immediate use. Enter Underfying ause (Disease or injury at initiated events sulting in death) Last FEMALE: 1b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	c	e of pregnancy 2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23e. Did to		Month I	•
by Physician/Medical	if Care C th re	any, leading to immediate ause. Enter Underfying ause (Disease or injury at initiated events sulting in death) Last FEMALE: 3B. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c	e of pregnancy 2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23e. Did to	obacco use	Month I	Day Year e cause of death?
by Physician/Medical	if Care C th re	any, leading to immediate ause. Enter Underfying ause (Disease or injury at initiated events sulting in death) Last FEMALE: 3B. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c	e of pregnancy 2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		1 🗆 Y	obacco use (es 2)Zîn	Month I	Day Year e cause of death? abiy 4 Unknov
by Physician/Medical	if Care C th re	any, leading to immediate ause. Enter Underfying ause (Disease or injury at initiated events sulting in death) Last FEMALE: 3B. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c	e of pregnancy 2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		1 1 3	obacco use /es 2/2/1 an 2 ssy rmed?	Month I contribute to the No 3 Proba 24b. Were autop prior to com death?	Day Year e cause of death? ably 4 Unknownsy findings availal apletion of cause of
Completed by Physician/Medical	IF 23	any, leading to immediate ause. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last FEMALE: Bb. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II, Other significant condition	c	e of pregnancy 2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	en in Part I.	24a. Was autop perio	obacco use /es 2) an 2 ssy rmed? 2 □ No	Month I contribute to the No 3 Proba 24b. Were autop prior to com death?	Day Year e cause of death? ably 4 Unknows by findings availa
Be Completed by Physician/Medical	IF 23	any, leading to immediate ause. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant conditions.	c	e of pregnancy 2 Fetal death at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	en in Part I. 26. Place of Dea	24a. Was autop perfo	obacco use (es 220 an 2 syrmed? 20 No	Month I contribute to the No 3 □ Proba	Day Year e cause of death? ably 4 Unknor by findings availa apletion of cause of 2 No
To Be Completed by Physician/Medical	If control of the results of the res	any, leading to immediate ause. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant conditions.	c	e of pregnancy 2 Fetal death tit time of death but not resulting in the	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) the underlying cause give	en in Part I. 26. Place of Dea	24a. Was autor perio 11 Yes ath (Check only o lome 5 Resid	an 22 No 20 No 100 No 1	Month Contribute to the No 3 Probate Prior to compensation of the Contribution of the	Day Year e cause of death? ably 4 Unknowns findings availa appletion of cause of the cause of
To Be Completed by Physician/Medical	If control of the results of the res	any, leading to immediate ause. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	c	e of pregnancy 2 Fetal death tit time of death but not resulting in the	3 Ectopic pregnancy 5 Other (specify) the underlying cause give patient 3 DOA The of 28c. Injury Wor	en in Part I. 26. Place of Dea	24a. Was autor perio 11 Yes ath (Check only o lome 5 Resid	obacco use (es 220 an 2 syrmed? 20 No	Month Contribute to the No 3 Probate Prior to compensation of the Contribution of the	Day Year e cause of death? ably 4 Unknor by findings availa apletion of cause of 2 No
To Be Completed by Physician/Medical	If control of the results of the res	any, leading to immediate ause. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant condition if II. Yes 2 No Manner of Death 1 Natural 5 Pending investig 3 Suicide 6 Could results.	Due to (or as d	e of pregnancy 2 Fetal death It time of death but not resulting in ent 2 ER/Outp yay Year) jury - At home, farr	3 Ectopic pregnancy 5 Other (specify) the underlying cause give patient 3 DOA The of 28c. Injury Wor	en in Part I. 26. Place of Dea er: 4□ Nursing H y at k?	24a. Was autor perio 11 Yes ath (Check only o lome 5 Resid	an 22 No 20 No 100 No 1	Month contribute to the No 3 Proba 24b. Were autoporior to comdeath? 1 Lives: Other (Specify, courred	Day Year e cause of death? ably 4 Unknown asy findings availat appletion of cause
To Be Completed by Physician/Medical	If control of the results of the res	any, leading to immediate ause. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No y Unknown at II. Other significant conditions iversity was case referred to medical examiner? 1 X Yes 2 No Manner of Death 1 Natural 5 Pending investig	Due to (or as d	e of pregnancy 2 Fetal death it time of death out not resulting in (3 Ectopic pregnancy 5 Other (specify) the underlying cause give patient 3 DOA Other 28c. Injury Wor 1)	en in Part I. 26. Place of Dea er: 4□ Nursing H y at k?	24a. Was autor perio 11 Yes ath (Check only o lome 5 Resid	an 22 No 20 No 100 No 1	Month contribute to the No 3 Proba 24b. Were autoporior to comdeath? 1 Lives: Other (Specify, courred	Day Year e cause of death? ably 4 Unknov say findings available pletion of cause of 2 No at scen
To Be Completed by Physician/Medical	Para 25	any, leading to immediate ause. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	Due to (or as d	e of pregnancy 2 Fetal death tit time of death but not resulting in the state of th	3 Ectopic pregnancy 5 Other (specify) the underlying cause give the under	en in Part I. 26. Place of Dea er: 4 □ Nursing H y at k? Yes 2 □ No	24a. Was autopoperto 10 Yes ath (Check only of 28d. Describe to 28d. Describe to 35d. and due to the and due to the	an 2 No ne) dence 6 two winjury of the ways of the ways of the cause(s) and the cause(s) are cause(s) and the cause(s) and the cause(s) and the cause(s) are cause(s) and the cause(s) and the cause(s) are cause(s) and the cause(s) are cause(s) and the cause(s)	Month contribute to the log 3 Probate	Day Year e cause of death? ably 4 Unknow by findings available pletion of cause of 2 No at Scen CVCA Route Number,
Be Completed by Physician/Medical	IF 25	any, leading to immediate ause. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	Due to (or as d	e of pregnancy 2 Fetal death tit time of death but not resulting in the state of th	3 Ectopic pregnancy 5 Other (specify) the underlying cause give the underlying cause give the underlying cause give the underlying cause give the underlying cause give the underlying cause give 28c. Injury Wor 1 X n, street, factory, office death occurred at the tire for investigation, in my of	en in Part I. 26. Place of Dea er: 4 \(\text{Nursing H} \) Yes 2 \(\text{No} \) ne, date and place pinion, death occu	24a. Was autopoperto 10 Yes ath (Check only of the the the the the the the the the the	an 2 2 No ne) dence 6 ne winjury ocause(s) and date and pla	Month contribute to the log 3 Probate	Pour Pour Pour Pour Pour Pour Pour Pour
To Be Completed by Physician/Medical	IF 25	any, leading to immediate ause. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	Due to (or as d	e of pregnancy 2 Fetal death tit time of death but not resulting in the state of th	3 Ectopic pregnancy 5 Other (specify) the underlying cause give the underlying cause give the underlying cause give attent 3 DOA The of Language attent wor 1 March attent according to the control of the contro	en in Part I. 26. Place of Dea er: 4 \(\text{Nursing H} \) Yes 2 \(\text{No} \) ne, date and place pinion, death occu	24a. Was autopoperto 10 Yes ath (Check only of the the the the the the the the the the	an 2 No say med? 2 No No No No No No No No No No No No No	Month contribute to the lo 3 Proba 24b. Were autop prior to comdeath? 1 Ves Other (Specify, courred Jumber or Rural d manner as sta	Poay Year Per cause of death? Ably 4 Unknown Posy findings available appletion of cause of
To Be Completed by Physician/Medical	IF 25	any, leading to immediate puse. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	Due to (or as d	e of pregnancy 2 Fetal death it time of death but not resulting in large any 2 PR/Outp any any any any any any any any any any	3 Ectopic pregnancy 5 Other (specify) the underlying cause give the underlying cause give the underlying cause give the underlying cause give 28c. Injury Wor 1xi n, street, factory, office death occurred at the tire for investigation, in my office 29c. Licens OCI	en in Part I. 26. Place of Dea er: 4 \(\text{Nursing H} \) Yes 2 \(\text{No} \) ne, date and place pinion, death occu	24a. Was autopoperto 10 Yes ath (Check only of the the the the the the the the the the	an 2 No say med? 2 No No No No No No No No No No No No No	Month contribute to the lo 3 Proba 24b. Were autop prior to comdeath? 1 Yes: Other (Specify, courred lumber or Rural dumber or Rural dumber on a stage, and due to	Pay Year Pe cause of death? Pably 4 Unknown Pay findings availate a poletion of cause of c
To Be Completed by Physician/Medical	IF 25	any, leading to immediate ause. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	Due to (or as d	e of pregnancy 2 Fetal death it time of death but not resulting in large any 2 PR/Outp any any any any any any any any any any	3 Ectopic pregnancy 5 Other (specify) the underlying cause give the under	en in Part I. 26. Place of Dea er: 4 \(\text{Nursing H} \) Yes 2 \(\text{No} \) ne, date and place pinion, death occu	24a. Was autopoper of the period of the peri	an 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N	Month contribute to the lo 3 Proba 24b. Were autop prior to comdeath? 1 Ves Other (Specify, courred Jumber or Rural d manner as sta	Pay Year Pe cause of death? Pably 4 Unknow Pay findings availal and a second cause of death? Pay findings availal and a second cause of death and a second cause of de

			1- For State of Maryland / Department / Department / Depa	artment of Health and M rtificate of Death		giene 005	18411
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Dea Month	ath Day Year	3. Time of Death
	Physici /Medi		MARCO RABINOVITZ		May	13 2005	6:07 A M
	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	th
			Suburban Hospital	Bethesda		Montgom	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day	y, Year) 9. Bird	hplace (State or Foreign
	Director		122-16-1537 Sum ZLIF 81 Yrs. Usual Residence of Decedent		Dec. 12	, 1923 Bra:	ila, Romania
	land ow		10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
	Many if sh	ţ	Maryland Montgomery Bethesda	9			1⊠Yes 2□No
	r 28a	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	puntry?
	h with	ie D	4504 Traymore Street	20814		U.S.A.	
	deat	Funeral		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
9	after or Ita	3	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No		Hican, etc.)		
8	ural',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: WW II	1 L Yes 2 X No Specify:		Specify: Wh:	ıte
21215-0036	filed within 72 hours after death with the Maryland Hygiene. thar than "natural", or Itams 23a or 28a-1 show ant, the Medical Exactive must be redified at	Completed	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ina	16b. Kind of Business	Industry
2	vithin ne. han	mpi	College (1-4or 5+)	DO NOT use retired)		National I	nstitute
N T	lled v tygie thar t	ပိ	5+ Years Rese	earch Biochemist		of Health	
Maryland	be f ntal h ad of	Be				Maiden Sumame)	
Ž	hould d Me mark matic	오	Morris Rabinovitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	Rachel M			
Ma	d 2 s th an 17 Is I			ng Address (Street and Number or Run			
တ်	1 an Heal am 2			Traymore Street, sition (Name of natory or other place)		a, Maryland 20c. Location - City or	
<u>o</u>	ages intof intof						
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show mortant: If item 27 is marked other than "natural; or Items 23a or 28a-f show in Items in Items 23a or 28a-f show any injury or other traumatic event, the Medical Event interment than 2000.	1		emorial Gdns 05/10		Olney, Mar	yland
ä	Dep Imp any onc		Norm A. Percenti	2. Name and Address of Facility INES-RINALDI FUNEI	RAL HOME	I, INC.	
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or feat failure. List only one cause on each line.	1800 New Hampshire or the mode of dying, such as cardiac	e Ave, S1 or respiratory arr	Iver Sprin	g. MD 20904 Approximate
	Fuysician:		A				Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. A CUTE M O Due to (or as a consequence of):	CARDIAL LI	IFARC	TION	
	Examiner	Ш	C C C A M A 2 V	ARTERY.	2716	ACE	
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	THE TURY.	DISCI	. 32	
	cuted	Examiner	Cause (Disease or injury that initiated events			-	
oʻ	e exe ian au irial-t	EX	resulting in death) Last Due to (or as a consequence of):				
68760	ificate be executed g physician and as the burial-transit	edicai	d				
_	artific ing p	Med	IF FEMALE:				
Вох	death certil e attending od for use a	an/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	Ectopic pregnancy		23d. Date of del	,
0	0 00	Physician/M	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown	Other (specify)		Month	Day Year
٦.	hat the de by	P.	Part II. Other significant conditions contributing to death but not resulting in the ur	nderhing equan in Part I	220 Did to	bacco use contribute to	the server of decays?
Vital Records,	requires that the	d by	VASCULAR DEMENTIA	nderlying cause given in Part I.	1 🗆 Ye	V	obably 4 Dunknown
Ö	w require been signature should b	ete	VASCOLONIA				
ě	e la has ye 2	ompleted			24a. Was a autops perforr	sy prior to d	topsy findings available completion of cause of
_ 	(Q LL	0	05.116		1□ Yes 2	2XNo 1 □ Yes	2 🗆 No
=	Physician: rthis certific ral director,	o Be	25. Was case referred to medical examiner? 1.27 yes 2.7 No. Hospital: 1.71 yes 2.7 No. 1.7 No	26. Place of Death Other: 4 Division No.			
ō	Phys r this ral dii	H	1 🔾 Yes 2 ☐ No ☐ Inpatient 2 🂢 ER/Outpatien 27. Magner of Death 28a. Date of Injury 28b. Time of	4 Nursing Ho		ence 6 Other (Spec	cify)
0	ttanding F death. tor: After the funera	ţ	1 Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	204. 0030100 110	ow injury occurred	
Division	or Attanding after death. Diractor: After in by the fune	ertification:	3 Suicide 6 Could not be 28e. Place of Injury - At home farm, stre		28f. Location (St	reet and Number or Ru	ral Route Number
S	af or Attand after death I Diractor:	erti	4 Homicide determined building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	City or Towr		
	To tha Hospital of within 24 hours at To tha Funaral D completely filled in	ical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place,	and due to the ca	ause(s) and manner as	stated.
	n 24 ha Fr	edic	(Check only 2 Medicel Examiner: On the basis of examination and/or inv	estigation, in my opinion, death occurr	ed at the time, da	ate and place, and due	to the cause(s)
	To the To the Complex	Σ	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Month	n, Day, Year)
	7-		MI Care Min.	D18084	1	1AY 15 2	005
			30. Name and address of person who completed cause of death (Item 23a) (Type, I	Print)	0		005
			30. Name and address of person who completed cause of death (Hem 23a) (Type, I D - O 2 I Z I M D - O 2 I Z I M S A TEL M D - O 2 I Z I M S A TEL M D - O 2 I Z I M S A TEL M D - O 2 I Z I M D - O 2 I M D	LONTHOJE FO	Kee	KVILLE IL	1) 20833_
	Sta		31. Date filed (Month, Day, Year) MAY 1 7 2005 32. Registrar's Signature	ule		•	
	Registra	all a	WITH I LOUS STOWN IN THE				

			1 - For Stata Registrar			artment of I		Mental Hygi	ene g. No. 201	15 tol. i
	Physic /Medi Exami	cal	Decedent's Name (First, Middle, Last John T	berts		4b. City, Town, o	or Location of Dea	2. Date of Death Month May 10,	Day Yea	4:50 A ^M
	Funeral Director		3521 Hamlet P1. 5. Social Security Number 6. Se 539-30-2467	x 7. Age	e (In yrs. last birthday Yrs.	Chevy If Under 1 Year Months Days				ery Birthplace (State or Foreign Country) Pennsylvania
	the Maryland	Director	10a. State 10b. County Maryland Montgomer 10e. Street and Number	ту	10c. City, Town or L			100	g. Citizen of What	10d. Inside City Limits 11 Yes 2 □ No
9036	be filed within 72 hours after death with the Maryland ital Hygiene. did other than "netural", or Items 23a or 28a-f show event, I're Medical Evanting toward by a citized at	by Funeral	3521 Hamlet P1. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates.	0	20815 Was Decedent of Hif Yes, specify Cub.			USA	merican Indian, hite, etc.
Maryland 21215-0036	e filed within 72 ho al Hygiene. I other than "netu vent, the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	cation	16a. Dece (Give life.	dent's Usual Occup e kind of work done DO NOT use retired	during most of wo	orking 16	Law Firm	,
aryian	should be and Mental I s marked o	To Be	Reed Turney Robe	rpe, Print)	19b. Maili	ng Address (Street	Virg	inia Lee J	Jones Dity or Town, State	, Zip Code)
saitimore, M	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumetic and once.		David Reed Roberts 20a. Method of Disposition 1 Burial 2 Kremation 3 F		9401	Duxford (osition (Name of matory or other place)	Ct. Poto	mac MD 208	354 oc. Location - City	or Town, State
Dali	permit. P Departme Importan any injur.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	Bug	51	2. Name and Addre	ss of Facility Jos nsin Ave	seph Gawle • NW Wasin	r's Sons gton DC	
	Medical Examiner	iner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Tary, Leading to humediate cause. Enter Underlying Cause (Disease or injury	Aspir. Due to (or as a		c or respiratory arrest		Approximate Interval Between Onset and Death 3 days 5 Years		
DOY 001 001	death certiticate be executed e attending physician and id for use as the burial-transit	ian/Medical Examiner	resulting in death) Last			∃Ectopic pregnancy			23d. Date of d	
	es that the gned by th be detache	0	1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions con	4 Pregnant at t 9 Unknown tributing to death but		Other (specify)	en in Part I.			Day Year to the cause of death? Probably 4 □Unknown
ם ב	the law ate has b page 2 s	e Completed	25. Was case referred to medical					24a. Was an autopsy performer	24b. Were a prior to death?	autopsy findings available completion of cause of
	S 5	examiner? 1 Yes 2 No							e 6 Other (Sp	ecify)
2	urs after de arel Directo	Certification:	3 Suicide 6 Could not be 4 Homicide det mined	28e. Place of Injur building, etc.		City or Town, S	State)	Rural Route Number,		
:	To the house after death or when might have house after death. To the Funerel Director: After the completely filled in by the funeral	Medical	29a. Certifier (Check only one) 29b. Signature and titl of certifier	ician: To the best of ler: On the basis of e and manner state	ixammation and/or inv	occurred at the time vestigation, in my op 29c. License D50	number		e(s) and manner a and place, and du Date signed (Mory 12, 200	e to the cause(s)
	20		30. Name and address of person who col David Rogers 5530	mpleted cause of dea	ath (Item 23a) (Type, 1 Ave. Che	Print)				
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 7 200		's Signature					

			1 - For State Registrar	State	of Marylan	-	artment o			nd M	lental		ene	NG	10	1 1	0
	Physici		Decedent's Name (First, Middle Mary C. Rode	e, Last)			***	-			2. Date Mont	of Death h	Day	Year		of Death	0 м
	/Medio Examir		4a. Facility Name (If not institution Montgomery Hospic		ŕ		4b. City, Town			Death	May	14,	4c. Count	y of Death	9:05	-	
	Funeral Director		5. Social Security Number 218–20–1136	6. Sex 1 □ M 2 🖾 F	7. Age (In yrs. 78	last birthday) Yrs.	If Under 1 Ye Months Da	ar If	Under 24	4 Hrs. Min.	8. Date (Mont	h, Day, Y	(ear)	Cour	place (State	e or Forei	gn
	Maryland I-f show fied at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Montor	omery	10c. Cit	y, Town or Lo								1	0d. Inside	City Limit	
	th with the 23s or 28s ust be roll	al Director	10e. Street and Number 9906 Capitol Vie				10f. Zip Cod					100	g. Citizen of USA	What Cour	ntry?		
036	be filed within 72 hours after death with the Maryland stal hygiene. d other then "neturel", or Items 23a or 28a-1 show event. I've Medical Evertiner must be rotified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marr 3 □ Widowed 4 □ Divorced	Armed F	2¾∑ No ive		Vas Decedent of Yes, specify C	uban, M	nic Origii lexican, i pecify:	n? (Spe Puerto	ecify Yes Rican, etc	or No-	Bla	ce - Amend ck, White, by:White	etc.		
9200-91212	filed within 72 ho Hygiane. ther then "netur ont, I'v Medical	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12) 12	t grade completed,) (1-4or 5+)	(Give life. I	lent's Usual Oc kind of work do DO NOT use rei	ne durin	n ng most o	of worki	ng	16	6b. Kind of E		dustry		
פ	2 should be filed and Mental Hygin le marked other raumatic event.	To Be Co	17. Father's Name (First, Middle, Charles R. Cleav	,		1 100	weeper	18.		_	(First, M		Hiden Sumai	anking me)			
e, Mar	f and 2 sho Health and Im 27 le m Her traum		19a. Informant's Name/Relations! Arthur H. Rode/ Hu		act F	9906	g Address (Stre			e, S	ilver	Sprir	ng, MD	20910			
saltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 le marked any injury or other traumatic es		20a. Method of Disposition 1 ▲ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S) 21. Signature & Funeral Service	pecify)	State C	emetery, cren John 's 1 Cemet		Churc	cn	May 200		W	ic. Location	•			
e D	perm Depa Impo any i		23a. Part1. Enter the disease, or	Scerl	caused the death	500	Name and Add	ity E	Blvd,	W, :	Silver	Spri	ing, MD	20901			
8	Pnysician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death)	a Bronc	each line. Chial Aden (or as a consequ (or as a consequ	ocarcino uence of):							,		Approxim Interval B Onset and	etween	
98790,	ficate be executed physician and s the burial-transit	edical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a consequ	uence of):											
.O. DOX	that the death certific ed by the attending p detached for use as	hysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	tcome of pregna birth 2 Petal nant at time of de lown	death 3	Ectopic pregnal Other <i>(specify)</i>					_		te of delive	ry Day	Year	
ords, r	The law requires that the ate has been signed by the page 2 should be detached.	ted by P	Part II. Other significant conditio	ns contributing to d	eath but not resu	alting in the un	derlying cause	ni nevig	Part I.		1		co use cont				ר
		Completed								_	8	Was an autopsy performed es 2 K	d?	Were autor prior to con death? 1 □ Yes	npletion of	s available cause of	9
on or vital	Phys this al dii	tion: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ② No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investig	28a. Date (Mon	- 1	ER/Outpatient 28b. Time of Injury	28c. In	other: 4 jury at lork?		ng Hom		Residenc	e 6 X]Oth injury occurr) Hospi	.ce	
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could n 4 Homicide determi	ot be ned 28e. Place build	of Injury - At hoing, etc. (Specify		et, factory, offic	ө	12.52	2	City or	Town, S				mber,	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner one) 29b. Signature and UIII-04 certifier 29c. License number 29d. Date signed (Minimum)										nner as sta and due to d (Month, L	the cause	s)			
	12		30. Name and address of person v				Print)	12	2 18		_		5/2	15/0	25		
	Sta Registra		Charles Harrison, 31. Date filed (Month, Day, Year)		1 Muncaste legistrar's Signat			kvil	le, M	bryl	and 20	0855					

			Please	Type or P State of							_		•	
			1 - For State Registrar	Glate of	iviai ytai i		rtificate				,	Reg. No	DAAC	101.11
		#	1. Decedent's Name (First, Middle, La	ist)	1						2. Date of De	ath	40.50	3. Time of Death
	Physic /Medi		ARTHUR LEVEN	ROE							Month	Day	y Year 2005	- 10125PM
	Exami		4a. Facility Name (If not institution, given				4b. City, 1	Town, or	Location of	of Death		4c.	County of Dear	th
			Doctor's Commun					nham					rince G	
L	Funeral Director		-	Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs. Ia	Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da Aug. 3	y, Year)	9. Bin Core Core	thptace (State or Foreign puntry) dova, MD
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Itam 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic avent, the Medical Eventrational terministic avent, the Medical Eventrational terministic avent.	Director	10a. State 10b. County	George's		Town or Lo								10d. tnside City Limits
	vith th	Dire	10e. Street and Number				10f. Zip (Code				10g. Cit	izen of What Co	ountry?
	s 23s	ra	6802 Beacon Place						737				U.S.A.	
	Item Item	Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married	12. Was Decede	s?		Nas Decede f Yes, speci	ent of His ify Cubas	spanic Ori n, Mexican	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	-	 14. Race - Ame Black, Whit 	
936	urs af	by	3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 tf Yes, Give Year or Date	□ № 194 s: 19		1 ☐ Yes 2	X No	Specify:				Specify:	1
215-0036	2 ho	Completed	15. Decedent's E			16a. Deced	ient's Usual	Occupa	ition			16b. Ki	md of Business/	hite Industry
21	within 7 ene. than "r	nple	(Specify only highest gn Elementary/Secondary (0-12)	College (1-4	or 5+)		kind of work OO NOT use				ng	Int	ernatio	onal Brother
21	filed wi Hygien other th	S	12			Maste	er Ele	ctr					lectrical	workers
P I	be fill Ital H Id oth	Be	17. Father's Name (First, Middle, Last								(First, Middle,		Sumame)	
Maryland	2 should be filed withir and Mental Hygiene. Is markad other than raumatic avant, the Mental Mental than the M	²	Thomas Raymond Ro								ile Sta			
Ma	nd 2 salth an 27 is r		19a. Informant's Name/Relationship (r Town, State, Z	
<u>ഉ</u>	permit. Pages 1 and 2 Department of Health Important: If itam 27 any injury or other tra once.		William A. Roe, S 20a. Method of Disposition	5011	20b. Pla	ce of Dispo	sition /Name	e of			e, Mary		1 20715 cation - City or	
Baltimore,	Pages ent of nt: If i		1 ☐ Burial 2 🌠 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		ite ce	тетегу, сгеп	natory or oth	he <i>r pl</i> ace	í !	E /1/	/05			
alti.	mit. F partm oortar inju		21. Signature of Funeral Service Lice		Metro	opolita , 22			s of Facilit	5/14, Yasa	h's Fur	Alex	Home,	Virginia P A
m	Depar Depar Impor any ir		Claudette	Dasch	San	ing 47	'39 Ba	ltin	nore.	Ave.	, Hyatt	svil	lle, Mar	vland
	Physician		Part1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each	sed the death.	Do not ente	er the mode	of dying	, such as		r respiratory ar			Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a conseque	ence of):					1			
	*	er	Sequentially list conditions, if any, leading to immediate		as a conseque									
	executed n and ial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	. De 010	iman	P	الات	- C) vi	A					
ó			resulting in death) Last		as a conseque			101	M. P.					
68760	ficate be physicial s the buri	Ilcal		d										
Box 6	ath certi attending for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		ne of pregnand	leath 3 🗌	Ectopic pred					2	23d. Date of delif	very Day Year
0	at the de by the stached	hysi	1 Yes 2 No 9 Unknown	9□ Unknowr			- Cirioi (spei							
s, D	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions of	ontributing to death	n but not result	ing in the un	derlying cau	use give	n in Part I.		23e. Did to	bacco u	se contribute to	the cause of death?
Vital Records,	w require been sig should b		HYPOTHYREINSIST	1 HJP	ではいい	الحا	CST	CO	20130	212	1 X Y	'es 2 [No 3□Pro	bably 4 Unknown
ecc	e law r has be je 2 sh	ompleted									24a. Was autop		24b. Were aut	opsy findings available
<u>=</u>	Th ate pag	Con									perfor		death? 1 ☐ Yes	
Vita	ysician: This certificate	Be	25. Was case referred to medical examiner?	Linesital:						of Death	(Check only o	ne)		
of	Phys this al dii	<u>1</u>	1 Yes 2 No	Hospital: 1 Minpa 28a, Date of Ir		R/Outpatient			4 🗀 Nur				Other (Spec	ify)
	ing After une	tlon	1 XNatural 5 ☐ Pending	(Month, I	Day Year)	8b. Time of Injury	M 280	C. Injury	at ? es 2 □ N		8d. Describe h	ow injury	occurred	
Division	ttan deat tor: the	fica	3 Suicide 6 Could not b		Iniury - At hom	e farm stre			63 2 1		8f Location /S	treet and	Number or Ru	ral Route Number,
Δ	al or /s after	Certification:	4 Homicide determined	building,	etc. (Specify)	,,	oi, idolory,	011100			City or Tow	n, State)		ar riodio reditioni,
	To tha Hospital or Attand within 24 hours after death To tha Funaral Director: /	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exem	ysicien: To the be niner: On the basis and manner	i of examinatio	edge, death n and/or inv	occurred at estigation, in	t the time	, date and nion, deatl	d place, a	nd due to the o	ause(s)	and manner as place, and due	stated. to the cause(s)
	To tha within 2 To tha complet	Σ	29b. Signature and title of certifier				29c.	License	number		2	29d. Date	signed (Month	, Day, Year)
ŗ			- Hill	HD				555	559			747	13,2	.005
	(10)		30. Name and address of person who		death (Item 2		Print)	DR	*	316-	داکلی	iria	· · · · ·	20170
#: #:	Sta		31. Date filed (Month, Day, Year) MAY 1 8 2005	■2. Regis	trar's Signatu	re	٠, ۲۰۰۰	16	-	1,100	7,		-1-71	
DHA	Registr MH 17 Rev 1/20	का औ	MM1 T 0 5003	Ploten	K	Grow	21							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 24a per Dr. C8/4 06/24/05dhb

MEND#8 5/19/05 State of Maryland Pepartment of Health and Mental Hygiene For AMEND#8 5/19/05 State O State Registrar AACO HEALTH DEPT. CMH Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician May 15, 2005 5:00 A Harry W. Stuart, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Annapolis Spa Creek Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year 3 21 1929 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**⊠**M 2□F New York Yrs. 76 108-20-8708 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23s or 28e-1 show any injury or other traumatic event, the Marical Extending the notified at once. 10a State 10h County 1 Yes 2 No Annapolis Maryland Anne Arundel Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21401 USA 930 Riversedge Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 1946-48 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White <u>გ</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 years Telecommunications Executive Lodging Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry W. Stuart, Sr. Agnes McCreedy ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 930 Riversedge Circle Annapolis, MD 21401 Florence M. Stuart/ Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5-17-05 Edgewater, MD * 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral SolV)ce Licersee 2973 Solomons Island Rd. Edgewater, MD 21037 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYONIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in daath) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has this certificate Attending Physician: 25. Was case referred to medical 26. Place of Death Check on one funeral director, Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of eath After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Hospitel or Attendi 24 hours after death. Funeral Director: A 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 4 T Homicide To the Hospitel within 24 hours a To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) nd title of certified 29b. Signature 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) AVE. #231 ANNAPOLIS, MD GOO PIDEELY J.M 31. Date filed (Month, Day, Year) State MAY 1 7 2005 Registrar

			1 - For State Registrar	State of Maryla		artmen rtificate			nd M		giene Reg. No.)5	18416
	Physic /Medi		Decedent's Name (First, Middle, Last) MARY SN	/I TH						2. Date of Dea Month MAY	Day	Year 2005	3. Time of Death
	Exami		4a. Facility Name (If not institution, give stre MONTGOMERY GENERAL	L HOSPITAL		OLN	EY	Location of			MOI	nty of Death	
	Funeral Director		5. Social Security Number 6. Sex 140-14-1190 1	2X F 85	s. last birthday) Yrs.	If Under Months	Days Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birtl (Month, Day Dec. 3.	Year) 1919	9. Birthp Coun New	lace (State or Foreign try) York
	e Maryland Se-f show Iilled al	ctor	10a. State 10b. County Md. Montgome		City, Town or Lo	ocation						1	0d. Inside City Limits 1 ☐ Yes 2 No
	ath with th 23a or 28 ust be no	rai Director	10e. Street and Number 19121 Bloomfield F	Road		10f. Zip	Code	2	0832		10g. Citizen o Unit	f What Coun ced St	•
9000	72 hours after death with the Maryland naturel', or Itams 23a or 28e-f show alical Exaculter coast by notified at	d by Funeral	1 Never Married 2 Married	Was Decedent Ever in Armed Forces? 1 Xyes 2 □ No If Yes, Give Year or Dates: W		Was Deced If Yes, spec	1	spanic Orig n, Mexican, Specify:	in? (Spe Puerto	ecify Yes or No- Rican, etc.)	14. R. B. Spec	ace - Americ ack, White, o	
21215-0036	d within 72 piena. Ir than "na	Completed	12		(Give	dent's Usua kind of won DO NOT us emake	k done d e retired)	ition uring most	of worki	ing	16b. Kind of Own F		dustry
Maryland	hould be filed d Mental Hygi markad other matic event, II	ø	17. Father's Name (First, Middle, Last) Joseph Walczyszy 19a. Informant's Name/Relationship (Type,		10h Maili	an Address		An	na	Duniec	:		
	1 and 2 si Heelth and 1 is rem 27 is rother traur		Wayne Paul Smith /	Son		Whet	ston		ve,	I Route Number Frederi		1. 23	1703
Baltimore,	permit. Pages 1 and 2 should be Department of Heelth and Menta Important: if item 27 is marked any injury or other traumatic evonce.		1 ☐ Burial 2 🗷 Cremation 3 ☐ Removed 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Servi > Lichnsee	oval from State	cemetery, crer etropol	itan (her place Crem	s of Facility	5/17	7/05	Alexan		Virginia
B	e m e g		23a. Parti. Enter the disease, or complicati shock, or heart failure. List only one c	ons that ceused the deause on each line.		P. 0	. B	ox_50	38,	Funeral Laytons r respiratory arr	ville,	Md.	20882 Approximate Interval Between
8760,	hysician and physician and the buriat-transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, a.y. leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a conse	nic h	Carl	Tl	isec	ise				years
.O. Box 6	The law requires that the death certifica He has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	in the past 12 months?	if yes, outcome of preg 1□Live birth 2□Fe 4□Pregnant at time of 9□Unknown	tal death 3	Ectopic pre	gnancy cify)					ate of deliver	y Day Year
Records, P	w requires that been signed I should be det	by	Part II. Other significant conditions contributions on tributions in the second of the	per choles	sulting in the un	nderlying car	use giver	in Part I.	nX	/ _	oacco use con es 2□No	atribute to the	a cause of death?
Vital Reco		Completed	blanch block 25. Was case referred to medical	COYD							ned?	Were autop prior to com death? 1 \(\sum \text{Yes} \)	sy findings available pletion of cause of
Division of Vil	To the Hospitel or Attending Physicien: whith 24 hours after deals as a feet deals To the Funeral Director: After this certifice completely filled in by the funeral director;	examiner? 1 Yes 2 No							ing Hom	(Check only only only only only only only only	nce 6 □Ot		
Divis	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	4 C Hornicide	8e. Place of Injury - At building, etc. (Spec	ufy)					8f. Location (Sti City or Town	, State)		
	the Hosp hin 24 hou the Fune appletely fil	Medical		n: To the best of my kr On the basis of examir and manner stated.	owledge, death ation and/or inv	estigation, i	n my opii	nion, death	olace, a occurre	nd due to the ca d at the time, da	use(s) and m ite and place,	anner as sta and due to t	ted. he cause(s)
	1271		29b. Signature and title of certifier	n)	- 02e) (T 1		D Z	12876	71	120DA	May	16, 2	
	Sta	20	30. Name and address of person who comple to the state of	ated cause of death (Ite	Olver	1 M	2	208	32	•	₽, M,.	- در	
	Sta Registra		MAY 1 7 2005	Bours 1	K Gos	de							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 12, **Physician** 2005 Sylvia R. Sears 8:30 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 F Director Yrs. 19, <u>218-07-</u>7878 Feb. 1918 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov itam 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Modical Examinar must be notified at Completed by Funeral Director 1 Yes 2 No Maryland Dorchester Cambridge filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 906 Hudson Rd. 21613 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: 3 ₩idowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Clothing Manufacturer 12 should be filed within hand Mental Hygiene.
7 Is marked othar than "! Elementary/Secondary (0-12) College (1-4or 5+) Seamstress & Hair Dresser & Beauty 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be timent of Health and Menta tant: If itam 27 is marked ပ Eugene Bennett Margie Seward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlene Spedden/Daughter 1368 Calvert Rd., Chester, MD 21619 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department of Important: If any injury or 2002. Spedden-Seward Cemetery 5/15/05 * 4 ☐ Donation 5 ☐ Other (Specify) Cambridge, MD 21. Signature of Foneral Service Licensee ^{22, Name and Address of Facility}
Curran-Bronwell Funeral F 308 High St., Cambridge, Funeral Home, 21613 the the disease, or compilirations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical due to (or as a consequence of Examiner YOUNALL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit Athersclerosis and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physiclan/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 Impatient 2 ER/Outpatient 3 DOA : After this funeral of 27. Manner 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Ulbillural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To tha Funeral 6

State Registrar

Medical

29a. Certifier

(Check only one)

Dennis

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20032. Regi var's Signature

Hall

888 Bestgate

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Rd. #215

29d. Date signed (Month, Day, Year)

				partment of Health and ertificate of Death	, ,	ene 1. No. 2005 101 10
	Physici /Medi		Decedent's Name (First, Middle, Last) JOAN ANITA SUNDAY		2. Date of Death MAY 15,	2005 Year 1:30 A M
).	Examir		4a. Fecility Name (If not institution, give street and number) 970 Highpoint Dr.	4b. City, Town, or Location of Dea	ath	4c. County of Death Anne Arundel
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 五 7. Age (In yrs. last birthda) 6. Sex 71 Yrs.			
	e Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I Maryland Anne Arundel Annap			10d. Inside City Limits 1 ☐ Yes 2 🌠 No
	th with th	al Director	970 Highpoint Dr.	10f. Zip Code 21 401	10g	. Citizen of What Country? USA
36	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Itams 23s or 28s-f show avant, I're Madical Evanting must be rediffed at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ▼Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	B. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 □ Yes 2 ☒ No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	vithin 72 hounde.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation re kind of work done during most of we DO NOT use retired)	orking	b. Kind of Business/Industry
.z pu	nd 2 should be filed within lith and Mental Hygiene. 27 Is marked othar than " r traumatic avant, It a Mer	Be Col	12th Scho	ol Bus Driver 18. Mother's Na	ame (First, Middle, Mai	oard of Education
ızla	should b id Menta marked matic a	ToE	Percy Booth 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	E iling Address (Street and Number or F	velyn Fitz	
	1 a Head		April Fleshman/ Daughter 970 20a. Method of Disposition 20b. Place of Disp	Highpoint Drive,	Annapolis	
Baltimore,	permit. Pages Department of I Important: If its any injury or or once.	l v	`4 □Donation 5 □Other (Specify) Kalas			dgewater, MD
ñ	permit. Departr Import any inj	1	World tal-	22. Name and Address of Facility GE 2973 SOLOMONS ISLA	AND ROAD, ED	GEWATER, MARYLAND 2103
	Fnysician /Medical Examiner	er.	23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		c or respiratory arrest,	Approximate interval Between Onset and Death ME Mountil
68/60,	ficate be executed physician and is the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			
O. Box	that the death certific ed by the attending p detached for use as i	hysician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
cords, P	w requires that the sbeen signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death? 2 No 3 Probably 4 Unknown
L	> 9 70	Completed			24a. Was an autopsy performed	
VITAL	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ⋈ No Hospital: 1 □ Inpatient 2 □ ER/Outpatie		ath (Check only one)	e 6 ☐ Other (Specify)
DIVISION OF	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Suneral Director: After this certificate has completely filled in by the funeral director, page 2.		27. Manner of Death 1 X Natural 5 Pending investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year)	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how i	
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	rreet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
	ha Hosp in 24 hou ha Funer pletely fill	edicai	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, dea 2 ★ Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occ	e, and due to the cause urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To T To I	2	29b. Signature and title of certifier Wm Wabb	29c. License number 0 24768		Date signed (Month, Day, Year)
			30 Name and address of person who completed cause of death (Item 23a) (Type William Dabbs, M.D. 277 Peninsula F	Print) Carm Rd. Annapolis	- MD 21401	
3	Sta Registra		31. Date filed (Month, Day, Year) MAY 1 7 2005 32. Registrar's Signature		, 21701	

		1 - For State Registrar		,	•	irtment of F tificate of			•	Reg. No.	105	1011
		1. Decedent's Name (First, Middle, Las	t)						2. Date of De	ath	J U J -	3. Time of Death
Physic /Medi		VIRGINIA EVE	LYN	SWE	RDA				May	Day 15	2005	3:40 a ^M
Exami		4a. Facility Name (If not institution, give	street and numi	ber)		4b. City, Town, o	r Location of	of Death		4c. Cou	nty of Death	
		Friends Nursing	Home			Sandy				Mon	tgome	су
Funeral		Social Security Number 6. Se	x 7 □M 2 1 20 F	'. Age (In yrs. last	-	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th y, Year)	9. Birthp	lace (State or Foreig
Director		579-28-2542		78	Yrs.				July 10), Year) 1926	Mary	'I'and
and		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation					1	0d. Inside City Limits
sho	5											1⊠Yes 2□N
the N	ect	Maryland Montgom 10e. Street and Number	ery	Sand	y Spr	1ngs 10f. Zip Code				10g. Citizen o	4 Mhat Caus	
with	ă	17330 Quaker Lan	o Ant	E 1		20860						itry :
72 hours after death with the Maryland natural", or Items 23a or 28a-f show alsel Examfrar must be notified at	Funeral Director	17 330 Quaker Lan		LI dent Ever in U.S.	13 1		isaania Ori	ain? (Soo	oity You or No	U.S.A	ace - Americ	ean Indian
fter d	F	1 Never Married 2 Married	Armed Ford	ces?	1	Vas Decedent of H Yes, specify Cuba	n, Mexicar	, Puerto	Rican, etc.)	В	lack, White,	
irs af		3 X Widowed 4 □ Divorced	If Yes, Give Year or Dat)	1	☐ Yes 2 No	Specify:			Spe	oify: Whi	te
2 hou	Completed by	15. Decedent's Ed		1	6a. Deced	ent's Usual Occup	ation			16b. Kind of	Business/Inc	dustry
n n	ple	(Specify only highest grad	de completed) College (1-4		(Give	kind of work done OO NOT use retired	durina mos	t of workir	ng			,
d within giene. r than "	E	12	College (1st	401 34)	Hous	e Wife				Own	Home	
ba filed within 72 hours after death with the Marylan tal Hygiene. Ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	Be C	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle,	, Maiden Sum	ame)	
should ba	ToE	Walter Payne					Mar	gare	t Final	.1		
2 should and Men is marke	-	19a. Informant's Name/Relationship (7	ype, Print)	1	19b. Mailin	g Address (Street	and Numbe	r or Rura	Route Number	er, City or Tox	m, State, Zip	Code)
and 2 salth a n 27 is		Lou Swerda - Son			5022	Mineola	Road	, Co	llege F	ark, M	ary1an	d 20740
- I 9 =	1 9	20a. Method of Disposition		20b. Place ceme	e of Dispos	sition (Name of natory or other place	(e)	D	ate	20c. Locatio	n - City or To	wn, State
Pages nent of nnt: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify)		tato				5/1	9/2005	Alexar	dria.	Virginia
그 든 뿐 글		21. Signatury of Funeral Service License	197/	Incer	22	Name and Addre	ss of Facilit	y Gas	sch's F	uneral	Home,	P.A.
Depa Impo any ic		1 11/1/1/1/1/	1 / any			739 Balt						
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that car	used the death. [Do not ente	r the mode of dyin	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between
Pnysician		Immediate Cause (Final	1.0		Stage	Renal D	icase	۵.				Onset and Death Year
/Medical		disease of condition resulting in death)	a	r as a consequen		rendi b	10000					l lear
Examiner												
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Uncertainty Cause (Disease or injury	b. Due to (or	r as a consequen	ce of):							
icate be executed physician and s the burial-transit	Examiner	that initiated events	С.									
an ar an ar irial-t	EX	resulting in death) Last	Due to (or	r as a consequen	ce of):							
ficate be executed physician and s the burial-transit	edical		d.									
		IF FEMALE:										
eath certifi attending I for use as	Physician/M	23b. Was decedent pregnant		ome of pregnancy		Ectopic pregnancy					Date of delive	*
that the death certi ad by the attending detached for use a	scl	in the past 12 months? 1 Yes 2 No		nt at time of death		Other (specify)					Month	Day Year
mat me de ad by the a detached	Phy	9 Unknown										
Se Un	by	Part II. Other significant conditions co	intributing to dea	ith but not resultin	g in the ur	derlying cause giv	en in Part I.				1	e cause of death?
en s	ted								10	Yes 2 No	3 Prob	ably 4 □Unknown
as b	Completed								24a. Was autop		. Were autor	osy findings available
ate pag	Son								perfo	rmed?	death?	2 No
or of	Be	25. Was case referred to medical					26. Place	of Death	(Check only o			
nysicia nis cert direct	2	examiner?	Hospital: 1 🔲 Ing	patient 2 ER/	Outpatient	3 DOA Oth	er: 4 Nu	rsing Hon	ne 5 🗆 Resid	dence 6 🗆 C	ther (Specify)
ng Ph ter th naral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of (Month,	Injury 28I Day Year)	b. Time of Injury	28c. Injun Wor	at	2	8d. Describe l	now injury occ	urred	
endij sath. or: Aj he fu	atle	2 Accident investigation					Yes 2 □ i	No				
r Att	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place o building	of Injury - At home g, etc. (Specify)	, farm, stre	et, factory, office		2	8f. Location (S City or Tox		nber or Rura	Route Number,
talo rsaft alDi	Cer											
tospl hou uner uner	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	sician: To the b	est of my knowled	dge, death	occurred at the tin	ne, date an	d place, a	and due to the	cause(s) and i	manner as st	ated.
To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After it completely filled in by the funara	led	one)	and manne	or stated.								
o tik o no	Σ	29b. Signature and title of certifier	10. VI	nd		29c. Licens	number	0		29d. Date sign	ned (Month, L	Day, Year)
		1/MACO	279			0/4	48	8		me	1/4,20	105
		30. Name and address of person who c	ompleted cause	of death (Item 23	a) (Type, F	Print)						
10												
10)		Thomas Dooley, M		4 Georgia gistrar's Signatura		nue, Sui	te 30	4, 0	lney, M	lary1an	d 2083	2

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 15, Nelson Velazquez May 2005 10:45A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 11502 Channing Drive Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 5. Social Security Number **Funeral** 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) 1 XM 2 ☐ F Director 263-42-9203 75 19, 1930 Puerto Rico Usual Residence of Decedent the Maryland 10a, State worle 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "naturel", or items 23c or 28e-f ehov treumatic event, the Nedical Evant scrinus be redified at Silver Spring Director Maryland Montgomery 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? with 11502 Channing Drive 20905 United States Funeral death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Item any injury or other treumatic event, the Mudical Engine 1 Tryes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1948 Baltimore, Maryland 21215-0036 1x Yes 2□ No Specify: Puerto Rican Specify: Hispanic þ 3 Widowed 4 Divorced 1952 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Electrical Engineer Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Eladio Velazquez MicaEla 0 Rojas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aracely Bermudez/Spouse 11502 Channing Dr; Silver Spring, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ^ 4 □ Donation 5 □ Other (Specify) Gate of Heaven Cem. May 19, 2005 Silver Spring, MD. Pope Funeral Homes 11315 Lockwood Dr. Silver Spring, MD. 21. Signature of Funeral Service-22. Name and Address of Facility icensee 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Ischemic cardiomyopathy /Medical Due to (or as a consequence of): Examiner Interstitial Lung Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed and -trans Atrial Fibrillation nding physician a Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐No detached 9 Unknown 9 Unknown signed by 1 3 be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown ted Complet 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed? page 1 ☐ Yes 2 No Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospitel or Attending After 1 Natural 5 ☐ Pending after death, Director: Aft d in by the fun investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 7. Bolalow 5/14/05 D47528 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lila M. Bahadori, M.D. 10301 Georgia Ave. Suite 304, Silver Spring, MD. 31. Date filed (Month, Day, Year) State Clark & Spell MAY 1 8 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 9:50 A M 2005 LILY PEARL WASHINGTON May 14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Montgomery Takoma Park If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖸 F 87 552.16.6802 Sept.1, 1917 Director San Diego, CA Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10d. Inside City Limits item 27 le marked other than "natural", or Items 23a or 28e-f show other treumatic event, the Medical Examinar must be notified at 1 ☑ Yes 2 ☐ No Alameda Berkeley Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1255 Delaware Street 94702 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 2 No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Tyes 2 No. Specify: Completed by 3 XWidowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clerk U.S. Government Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be file ment of Health and Mental Hy tent: If item 27 le marked oth Be Jesse Lyles Rose ٩ (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois E. Bullard/Daughter 2806 Curry Drive, Adelphi, Maryland 20783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State injury or 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State permit. Page Department of Importent: If 05/20/2005 Oakland, California Evergreen Cemetery ⁴ □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Immediate Cause (Final disease or condition) HINES-RINALDI FUNERAL HOME, Spring, MD 20904 Approximate Interval Between Onset and Death ther is elecosis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter or outlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has page 2 autopsy performed? 1 ☐ Yes 2X No Physiclan: director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 🎛 No 1 ☐ Inpatient 2 X ER/Outpatient 3□ DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After or Attending 1 X Natural 5 Pending Injury within 24 hours after death. To the Funerel Director: A 1 🗀 Yes 2 No investigation 2 Accident the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospitel 1 🛛 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 9c. License number 9 D-35826 May 15, 2005 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll Avenue, Takoma Park, Maryland 20912 Horacio Schapiro, M.D., 31. Date filed (Month, Day, Year) 32/Registrar's Signature State 7 2005 Registrar

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene [] [] [Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 12, **Physician** 2005 1022A. Anton D. Williams Sr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Hospital Center Cheverly Prince Georges If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 25,1951 Wash DC 1 X M 2 □ F Months 53 September 577-70-6977 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 28a-f show instrust by notified at DC Washington DC 17 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ō 2224 Savannah Terrace #23 Was Decedent Ever in U.S. armed Forces?

13. Was Decedent of Hispanic Origin? (Specify Yes or No-1/2) Items 23a United States death \ Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō by Specify: traumatic event, If a Madical Exa-75 If Yes, Give Year or Dates: 2 Dec 3 Widowed 4 Divorced Black. "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Supervisor/Mover Private Pages 1 and 2 should be filed venent of Health and Mental Hygie ant: If item 27 is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle, Last) Be James E. Williams Virginia Taylor 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Linda Williams /Wife 2224 Savannah Terr. S.E. #23 Washington DC 20020 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. N Burial 2 Cremation 3 Removal from State Quantico National Cem 5-19-05 Triangle, VA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Alexander S. Pope Funeral Home aloria ant 2617 Penn. Ave S.E. Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arterioscherofic Pnysician Hypertensive disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the 8 9 Unknown à Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2XNo 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No 24a. Was an page 2 s has autopsy performed? certificate 2 No Yes Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 🛣 EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 ☐ No 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Vatural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only within 2 29d. Date signed (Month, Day, Year) 29c License number 29b. Sign May 13, 2005 OCME who completed cause of death (Item 23a) (Type, Print) MI 111 Penn Street Baltimore, Maryland 21201 State

Registrar

31. Date filed (Month, Day, Year)
MAY 1 8 2005

			State of Maryland / D	epartment of Health and M Certificate of Death	•	ne 2005 181.4	23
1	there &		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of De	eath
	Physici /Medi		ANNE MARIE YUSKO		Month I	2005 9:12 A	7 м
j	Examir		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Doctor's Community Hospital	Lanham		Prince George's	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	rs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or F Country)	oreign
	Director		015-36-9797		July 26, 1	.946 Massachuset	TS_
	show		10a. State 10b. County 10c. City, Town	or Location		10d. Inside City I	Limits
	e Mai	cto	MD Prince George's Colleg	e Park		1X Yes 2	□No
	with the Marylar a or 28e-1 show	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?	
	s 23a	rai	5005 Huron Street	20740		U.S.A.	
	Item	Funerai	11. Marital Status 1 □ Never Married 2 ☑ Married 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	ecity Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.	
936	urs af	ρ	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: White	
5-0036	within 72 hours after death with the Maryland ene. Han "neturel", or Items 23e or 28e-f show re Medical Exercitivations	Completed	15. Decedent's Education 16a. I (Specify only highest grade completed)	Decedent's Usual Occupation	ing 16b.	Kind of Business/Industry	
. 2	within 7 jiene. r than "n	nple	Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done during most of work life. DO NOT use retired)			
2	D 0 0			ocial Worker		Private Business	
and	t be filed ntal Hyg ed othe	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	en Sumame)	
Maryland	d 2 should be th and Mental ? Is marked of treumatic eve	2	Peter Demartino 19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and Number or Run	n Capone	v or Town State Zin Codel	
			1 1 1 1	05 Huron Street, Col			0
<u></u>	is 1 and 2 of Health Item 27 is	1 3	20a. Method of Disposition 20b. Place of		7	Location - City or Town, State	
e E	Page nent o int: If		T Bullar 2 K Clemation 3 Themoval non/ State	itan Crematory 05/1	4/05 Ale	exandria, Virgini	а
7. Baltimore,	permit. Pages 1 a Department of Hes Important: If Item any injury or othe		21. Signalure of Juneral Service London	22. Name and Address of FacilityGaso			
<u> </u>	8978		tout lay	4739 Baltimore Ave.	, Hyattsv	ille, Maryland 20)781
			23a Part1. Enter the disease, or complications the caused the death. Do no shock, or heart failure. List only one cause in each line.	ot enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Betwee Onset and Dea	en
	Physician		Immediafe Cause (Final disease of condition resulting in death)	filmlelm		Onset and Dea	IUI
- 1	/Medical Examiner		Due to (or as a consequence of	n: 1			
		- io	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of	heat die			
	nted I Insit	Examiner	cause. Enter Underlying	r			
Ċ	te be executed ysician and e burial-transit	Exa	that initiated events resulting in death) Last c. Due to (or as a consequence of	i):			
1760,	9 × it	cai	d				
89	or Attending Physicien: The law requires that the death certificat ster death. Sifector: After this certificate has been signed by the attending phy in by the funeral director, page 2 should be detached for use as th	Physician/Med	IF FEMALE:	enterno la			
Вох	ath ce	ian/	23b. Was decedent pregnant in the pact 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	3 □Ectopic pregnancy		23d. Date of delivery Month Day Yea	ır
P.O.	he de the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		/	
	that the died by the detached	/Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of deat	:h?
rds	quires in signe	d by	Hypo Kelmin.		1 🗆 Yes	2 No 3 Probably 4√Unk	nown
000	aw requir as been si 2 should	Completed	Remails file		24a. Was an	24b. Were autopsy findings ava	ıılable
Be	The lav	E O			autopsy performed 1 ☐ Yes 2 2 1		e of
ital	ysicien: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?	26. Place of Deatl	(Check only one)		
) >	Physic this ce al dire	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp		me 5 ☐ Residence	6 ☐Other (Specify)	
n o	ding Phy h. After thi funeral	ion:	A liverial of the liverial of	ury Work?	28d. Describe how in	jury occurred	
Division of Vital Records,	ttendi death. stor: A / the fu	icat	2 Accident investigation 3 Suicide 6 Could not be determined elements.	M 1 Yes 2 No	28f Location (Street	and Number or Rural Route Number	
Σį	after Dire	Certification;	4 Homicide determined 288. Place of injury. Althorne, fair building, etc. (Specify)	ii, street, ractory, omce	City or Town, Sta		,
	spite hours inerel y fillec	aic	29a. Certifier 1X Certifying Physician: To the best of my knowledge,	death occurred at the time, date and place,	and due to the cause	(s) and manner as stated.	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edicai	(Check only one) Medical Exeminer: On the basis of examination and and manner stated.	ror investigation, in my opinion, death occurr	ed at the time, date a	and place, and due to the cause(s)	
	With To t	Σ	29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month, Day, Year)	
			I les jour physican	120633		1/2/65	
<u> </u>	(3)		30. Name and address of person who completed cause of death (Item 23a) (TWILLER IN A CRUZ 8118 (Type, Print) Sood Luck 12d	Lanh	an Ind 2070	6
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 8 2005 Registrar's Signature	books.			

			1 - For State Registrer	State of Maryland / Depa	artment of Health and rtificate of Death	Mental Hygier	The Y
	Physic		1. Decedent's Name (First, Middle, Last	Adelison		2. Date of Death	3. Time of Death
	/Medi Examii		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Dea	ath May 28	4c. County of Death
	Funeral Director		5. Social Security Number 217 24 0490 Usual Residence of Decedent	CAR & x 7. Age (In yrs. last birthday) M 2 F 7 Yrs.	BP1 Family 1: If Under 1 Year If Under 24 Hr Months Days Hours Min		9. Birthplace (State or Foreign Country)
	he Maryland Ba-f show	ector	10a. State 10b. County M.D N/A	10c. City, Town or Lo BALLIMO			10d. Inside City Limits ✓ Yes 2 □ No
	ath with t	Funeral Director	514 Tunhadge	Rd	10f. Zip Code		Citizen of What Country?
9036	72 hours after death with the Maryland natural', or items 23a or 28a-f show ilical Examiner must be invitiled at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ❷ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 1 No	Was Decedent of Hispanic Origin? (f Yes, specify Cuban, Mexican, Pue	Specify Yes or No- into Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	I within piene. r than "	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	le completed) (Give	dent's Usual Occupation kind of work done during most of wi DO NOT use retired) COLE TRY OF EL	orking	Kind of Business/Industry FOINE COKE PROVICES
Maryland ?	nould be filed I Mental Hygid narked other natic event, III	To Be C	17. Father's Name (First, Middle, Last) Alon 20 13/49,155			ame (First, Middle, Maide	en Sumame)
	ges 1 and 2 should it of Health and Mer If Item 27 Is marke or other traumatic		19a. Informant's Name/Relationship (Ty SunMa SHIE 20a. Method of Disposition	20b. Place of Dispo	Tunbulge Rd Bristion (Name of	Date 200	Docation - City or Town State
Baltimore	permit. Pages Department of Important: If It any injury or o once.		15 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 21. Separature of Funeral Service Licens	Removal from State Ning MEn	natory or other place) Name and Address of Facility	105 BAS FUNER	1 finance MO
	₽ □ = 9 0		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death. Do not enter	129 MI CURRELINE	St BRIT	Approximate Interval Between
68760,	tificate be executed by provided as the burial-transit as the burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): MALNUTRIT! Due to (or as a consequence of): Due to (or as a consequence of):		OOR OPAL	Onset and Death
P.O. Box 68	The law requires that the death certifica te has been signed by the ettending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ► No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ords, P	equires that sen signed b ould be deta	by	Part II. Other significant conditions cor	ntributing to death but not resulting in the un RENAL FAILL	dertying cause given in Part I.		use contribute to the cause of death?
		Completed	26. Was again referred to modified			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No
Division of Vital Records,	for the Hospital or Attending Physician: within 24 hours after death, To the Funeral Director: After this certifical completely filled in by the funeral director,	atlon: To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	04	ath (Check only one) Home 5 Residence 28d. Describe how inju	
DIX	To the Hospital or Attending Ph within 24 hours after death, To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)		City or Town, Star	13
	To the Hospital within 24 hours a To the Funeral C completely filled	edical	29a. Certifier (Check only one) 2 Medicel Exemination	ician: To the best of my knowledge, death ner: On the basis of examination and/or invand manner stated.	occurred at the time, date and place estigation, in my opinion, death occu	e, and due to the cause(s arred at the time, date ar	s) and manner as stated. Indicates and due to the cause(s)
	To To Corr	Σ	29b. Signature and title of certifier	relimo	boolb 7	8-9. JUN	ate signed (Month, Day, Year) /E 2 . 2005
	6		30. Name and address of person who co. LORRATINE OF OF	mpleted cause of death (Item 23a) (Type, F + HWUHH, 5201 LO	National Control		
	Sta Registra		31. Date filed (Month, Day, Year)	32. Jegistrar's Signature	edi)		

			For Stata Registrar	State	of Ma	ryland / I	-	artmen rtificate			and M	ental Hy	giene	1115	18425
	Dhusisi		1. Decedent's Name (First, Midd									2. Date of De Month	ath Day	Year	3. Time of Death
	Physici: /Medic			Anderso				1				May 27			4:30 P M
į	Examin	er	4a. Facility Name (If not institution Bradford Oal)		number)				Town, or .ntor	Location o	of Death			County of Dea	
	Franci		5. Social Security Number	6. Sex	7. Age	(In yrs. last bit	rthday)	If Under	1 Year	If Under		8. Date of Bir	th		George's
	Funeral Director		337 12 2195	XX M 2□	_	82	Yrs.	Months	Days	Hours	Min.	Aug 4,	1921 1921	2 Chi	country) Lcago, III
	p >		Usual Residence of Decedent 10a. State 10b. County			10c. City, Tow	m or lo	cation							10d. Inside City Limits
	shov	5	,			- ,,									1 Yes 2 No
	286-1	Director	10e. Street and Number	ce George	2	Upp	oer_	Marlb 101. Zip					10g. Citi	zen of What C	Ountry?
	3a or		8505 Lac	nine Cou	rt					20772			Uı	nited S	States
	death	Funerai	11. Marital Status	12. Was D	ecedent E Forces?	ver in U.S.	13.	Was Deced	lent of Hi	ispanic Ori	gin? (Spe	cify Yes or No Rican, etc.)		14. Race - Am Black, Wh	erican Indian,
36	hours after death with the Maryland tural; or Items 23s or 28e-f show of Ezani art must be rollified at	by Fu	1 Never Married 2 Mar	ried 1 TY	s 2 □ N Give	• 1942-		1 ☐ Yes		Specify:	,	,,			hite
21215-0036	a within 72 hours after death with the Marylen tiene. r then "natural", or items 23a or 28e-1 show the Medical Examination at the relities at	q pa	3 Widowed 4 Divorced	Year of Year o	or Dates:	1946	Dece	dent's Usua	d Occupa	ation			16h Kii	nd of Business	
15	nin 72 n "nal	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade complete	e (1-4or 5-		(Give	kind of wor DO NOT us	rk done d	durina mos	t of worki	ng	105.11		2303tty
212	d within giene. er then "	Com	12	Colleg		·	C	ommer	cial	Sale	es		Ut	cility	Company
nd	I be filed ntal Hygi ad other event, t	Be	17. Father's Name (First, Middle, Harry John									(First, Middle			7
yla	should be and Mental s markad o	7	19a. Informant's Name/Relation:			101	h Mailie	a Addrasa	(Street)			tte E1			lson
Maryland	d 2 :		Robert Anderso			130						rlingt			
ē,	is 1 and Healt Item 2 other		20a. Method of Disposition			20b. Place o	of Dispo		ne of		une			cation - City o	
Baltimore,	Pages nent of int: If Its iry or o		ty Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (\$	3 □Removal fr Specify)	om State		and	Vete	rans	Ceme	etery	2005	Che1	tenham	, Maryland
alti	permit. Page Department of Important: If any injury or once.		21. Signature Funeral Service	Liven ge	9		22	2. Name an	d Addres	ss of Facilit	y Le	e Fune:	ral h	lome,In	c 663301d
	20153		MAGA	Thele	1-20	0155								, Mary	land 20735
I			23a. Part 1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final	t only one cause	on each lin	e						No.			Approximate Interval Belween Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Duo		consequence		~/	pin	eur	40	Ma	_		
P	Examiner			Pa		12500	3	5 %	1,50	cic	.0	ille			
4	7 -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			consequence		•							
V	and transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last	C		consequence									
8760,	be executed sician and burial-transit	ai E	Todaling in adding date		sle	blood	_	11105	50	re					
687	ate he	edicai		dt	700	1,000	/								
Вох	eath certific attending pl for use as t	M/u	IF FEMALE: 23b. Was decedent pregnant			of pregnancy 2 Fetel death	h 3.F	∃Ectopic pr	ennancv				2	23d. Date of de	*
	e deat he att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pi		time of death		Other (sp						Month	Day Year
P.0	The law requires that the de sie has been signed by the a bage 2 should be detached		9 Unknown Part II. Other significant condit			it not resulting	in the u	nderlying c	ause civi	en in Part I		23e. Did	obacco u	se contribute l	to the cause of death?
ds,	signe d be d	d by	arti. Gallor organical						addo g.r.	O17 111 1 G1 1 1	•		Yes 2		robably 4 Mnknown
Records,	w require been signal	ompieted										24a. Was	an	24b. Were a	utopsy findings available
Re	The larele has	omp										auto perfo	rmed?	death?	completion of cause of s
Vital		BeC	25. Was case referred to medical examiner?	al						26. Place	of Death	(Check only			
of V	Physiclan: this certific ral director,	은	1 ☐ Yes 2 🔀 No		□Inpatier							me 5 Resi			ecify)
	Ing After une	tlon:	27. Manner of Death 1 Natural 5 ☐ Pend	ng (/ igation	ate of Injury Month, Day	Year) 28b.	Time o Injury	if 2	8c. Injury Work	yat k? Yes 2. □		28d. Describe	how injur	y occurred	
Division	or:	Certification;	3 ☐ Suicide 6 ☐ Could	not be 28e. P	lace of Inju	ıry - At home, f	am, sti			.00 .0	-				Rural Route Number,
	al or / s after il Dire	Serti	4 Homicide deten	ь	uilding, etc	. (Specify)						City or To	wn, State,	}	
	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by ti	edicai ((Check only 2 Medice	ng Physicien: To I Examiner: On th	e basis of	examination a									
	ithin 2 o the	Med	one) 29b. Signature and title of certifi		nanner sta	180.		290	c. License	e number			29d. Date	e signed (Mon	th, Day, Year)
	F ≯ F 8		Mulal	Ville	ely.	100		MI	o it	004	244	5	May	31,	2005
	10+1		30. Name and address of person				(Туре,	Print) 6	67 1 1	PERST	OF	FILE	no	1410,1-	11-
	1-		MICHAEL PIF			ur's Signature			WITL	-NOIL	F, 1	171246	17,10%	1 20	602
	Sta Registi		. IIIN 0 S		Bearing		1	and I	•						
			- JUIN U.6	/ 1/6/.	Total Control	- FEE	-	19,175							

			For State Registrar	tate of Ma	ryland / Depa <i>Ce</i>	artment of F			giene 🗍 🗍 Reg. No.	15 18426		
			Decedent's Name (First, Middle, Last)					2. Date of De	ath	3. Time of Death		
	Physici		Hazel Elizabeth	Anders	on			Month May 27	, 2005	17:50 M		
	/Medi Examir		4a. Facility Name (If not institution, give stre			4b. City, Town, o	r Location of Death		of Death			
			Harford Memorial	Hospital		Havre	de Grace		Ha	rford		
	Funeral Director		5. Social Security Number 6. Sex 1 M	7. Age	(In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Jan. 2	y, Year)	Birthplace (State or Foreign Country) Maryland		
	pu k		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits		
	faryla shor	ö								1 ☐ Yes 2√5 No		
	28e-I	Director	Maryland Harford 10e. Street and Number		Havre	e de Grac	e		10g. Citizen of W	/hat Country?		
	3a or		1605 Glenville Roa	d			1078		_	SA		
	deeth ms 2	era	11 Marital Status 12.	Was Decedent E	ver in U.S. 13.	Was Decedent of H	ispanic Origin? (Sr	ecify Yes or No	- 14. Race	- American Indian,		
336	permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 Is marked other then "naturel", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examinating the motified at once.	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ত Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2 XNo If Yes, Give Year or Dates:		if Yes, specify Cuba 1 ☐ Yes 2 ☑ No	in, Mexican, Puerto Specify:	Hican, etc.)	Specify:	k, White, etc. : White		
Ö	2 hou	ted	15. Decedent's Educati	on on	16a. Dece	dent's Usual Occup	ation	daa	16b. Kind of Bus			
Maryland 21215-0036	within 7 ene. then "n he Medi	Completed	(Specify only highest grade co	College (1-4or 5+)	nemaker	during most of work	ang	Own Ho			
0	filed Hygi other	Be C	17. Father's Name (First, Middle, Last)		, IIO	ICHICI	18. Mother's Nam	e (First, Middle,	Maiden Sumame			
an	should ba nd Mental marked c	To B	Alfred Stanley	Tyson			Helen	Elizabe	th Walk	ær		
ary	should have		19a. Informant's Name/Relationship (Type,	Print)	19b. Mailir	ng Address (Street	and Number or Rui	al Route Numbe	er, City or Town, S	State, Zip Code)		
Σ	and 2 salth a n 27 Is		Carol Smith / Sister	<u> </u>	808 5	Seabreeze	Road, Ca	mbridge	, Maryla	and 21613		
ore	of He of He fiten r oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Rem	aval from State	20b. Place of Dispo cemetery, crer	sition (Name of natory or other plac	xe)	Date	20c. Location - 0	City or Town, State		
Ĕ	Pages ment of the ent: If Ite		'4 □Donation 5 □Other (Specify)	Svai iroini State	Harford	Memorial	Grans 5-	3-05	Aberdeen	n, Maryland		
Baltimore,	permit. Departr Import any inj		21. Signature of Funeral Service Licensee	Der	h	317 Coke	ss of Facility Ineral Ho Sbury Roa	d Ahin	and another	aryland 21009		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complications of the complex of the comp	ons that caused to	he death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between		
			Immediate Cause (Final disease or condition		Onset and Death							
			resulting in death)	Aue to (or as a	consequence of):	n poo	were	7				
			Sequentially list conditions b	Hero	sclentic	Codiva	scule !	1 iseas	نع ک	20-25		
. /		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):							
V	cate be executad physicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last									
8760,	be ex icien burial			D00 to (01 a3 a	consequence of):							
387	phy phy	dicai	d									
D. Box (The law requires that the death certifiate has been signed by the attending rage 2 should be detached for use as	by Physician/Me	in the past 12 months?	If yes, outcome of 1□Live birth 2 4□Preg <i>nan</i> t at ti 9□ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery th Day Year		
P.0	that the do ned by the detached	Phy	Pag-IL Other significant conditions contrib	uting to death but	not resulting in the u	nderlying cause give	en in Part I	23e. Did to	obacco use contril	bute to the cause of death?		
ds,	signe d be		Cerun de orda	10		, , , , ,		101	res 2 □ No	3 Probably 4 Onknown		
Ö	w require been sig should b	ete	The cool certific					24a. Was	20 24h W	fore autopsy findings available		
Il Records,	iclen: The law certificate has ector, page 2 :	Completed						autop	rmeg pr	/ere autopsy findings available rior to comptetion of cause of eath? ☐ Yes 2☐ No		
Vital	Physiclen: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ital:		Oth	26. Place of Deat	h <i>(Check only</i> o	ne)			
of	Phys this al dir	7	1 Yes 2 No Hosp	inpatient			4 Nursing He		lence 6 Other			
	ling After	tion	Taratara o la oridaria	8a. Date of Injury (Month, Day)	Year) Injury	Worl	Yes 2 □ No	Zod. Describe i	now injury occurre	ď		
Division	or Attending after daath. Diractor: After in by the funer	fical	6 Could get be	8e. Place of Injur	v - At home, farm, str		103 2 110	28f. Location (S	Street and Number	r or Rural Route Number,		
Θ	after after Dira d in b	Certification:	4 Homicide determined	building, etc.	y - At home, farm, str (Specify)	201, 120101, 101100		City or Town, State)				
	To the Hospitel or Attent within 24 hours after daath To the Funerel Diractor: completely filled in by the	Medical C	29a. Certifier Check only one) Certifying Physicia 2 Medical Examiner	n: To the best of	my knowledge, death xamination and/or inv	occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the dred at the time, d	cause(s) and man date and place, ar	ner as stated. and due to the cause(s)		
	To the within 2 To the complet	Me	29b. Signature and trip of certific	/		29c. License				(Month, Day, Year)		
	->-0		1/1/	740	FINN P	1/20	1877	1/	1/11/20	x 1005		
	, a		30. Name and address of person who compl	eted cause of dea	ath (Item 23a) (Type	Print)		(1)	ALLY C	11/20-		
			VITTER LOPRESTY	00 1	308 B	151485	Conta	May	Edgen	JUV 21040		
	Sta Registr		of Date filed (Month, Day, Year) JUN 0 2 2005	32. Registrar	s Signature					,		
		7.1	2011 0 10 2273		10							

DHMH 17 Rev 1/2001

Anderson, Haze

UNK 05-03620		Please	Type or Print								
05 - 03620 RPD		1 = For State Registrar	State of Mar			ent of He ate of De		ental Hy	ygien Reg. N	71105	181.2
Physici	an	1. Decedent's Name (First, Middle, Li	ast)	D	1,			2. Date of D	eath	ay Year	3. Time of Death
/Medic Examin	cal	John Chris 4a. Facility Name (If not institution, gi	Topher	Boy	VIII	ity Town or la	ocation of Death	May 2	6, 2	005 c. County of Death	0849 A M
Examin	Ci	4408 Franconia D			Ва	ltimore			4	N/A	
Funeral Director			Sex 7. Age ((In yrs. last birth	mday) If Un Monti		f Under 24 Hrs. Hours Min.	8. Date of B (Month, D	irth Pay, Year	9. Birth	place (State or Foreign intry) hington, D. (
**************************************	_	10a. State 10b. County		10c. City, Town	or Location	1 1		,			10d. Inside City Limits
ith the Marylar or 28a-f show	recto	Maryland Frince 10e. Street and Number	Georges	Gre		elt Zip Code			10a C	itizen of What Cou	1 ☐ Yes 2 🕱 No
ath with	ral D	157 Westy	yay #20%			2071	70		.09.0	USA	nay.
15-0036 72 hours after death with the Maryla "naturel", or items 23e or 28a-1 shou	Funeral Director	11. Marital Status 1 A Never Married 2 Married	12. Was Decedent Even Armed Forces? 1 ☐ Yes 2 ☑ No		13. Was De If Yes, s	cedent of Hispa pecify Cuban, I	anic Origin? (Spe Mexican, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Ameri Black, White,	can Indian, etc.
003(Ď	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 X No 5	Specify:			Specify: B/	ack
215- 10 72 In 72 In mat	Completed	15. Decedent's E (Specify only highest gr	ade completed)		ecedent's U Give kind of life. DO NO	sual Occupatio work done duri Tuse retired)	in ing most of worki	ing	16b. I	Kind of Business/In	dustry
d 212 filed with Hygiene other the	Com	Elementary/Secondary (0-12)	College (1-4or 5+)		1.0	mple	yed		N	ever V	Vorked
Baltimore, Maryland 21215-0036 semit. Pages 1 and 2 should be filed within 72 hours aft opportunit of Health and Mental Hygiene. Important: If I tem 27 is marked other than "naturel", or my injury or other treumetic event, the Mudical Exemples.	To Be	17. Father's Name (First, Middle, Last	Boulin			18	Mother's Name	(First, Middle	Maide	n Sumame)	D. I
fary 2 shou and M Is mar eumet	-	19a. Informant's Name/Relationship	Type, Print) (Fathe	25) 196.1	Mailing Addre	ess (Street and	Number or Rura	I Route Numb	er, City	or Town, State, Zip	Code)
re, N Health Health tem 27		Nr. Leon C. E	Soulin	20b. Place of D	Disposition (A	2 STW	ay =20	2 G	reer	ocation - City or To	1 20770
affimol nit. Pages artment of orient: If it injury or of		1 ☐ Burial 2 XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	Green N	Crematory o	cremate	6/2/	2005	7	alto N	1 d
Baltimore, N permit. Pages 1 and pepartment of Health Importent: if item 21 any injury or other tr		21. Signature of Funeral Service Lice	P P	aree in	Josep	and Address o	Facility	unero	1 1-1	tome. P. F	1.
		23a. Part I Enter the disease, or com	plications that caused the	ne death. Do no	222Z t enter the m	WiNor and ode of dying, s	uch as cardiac o	r respiratory a	m. 1	Md. 212	Approximate
Frysician		Immediate Cause (Final disease or condition	one cause on each line.	tenle			Shar	n Fa/10	To	C	Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a c	cons uence of				10100		freezes	
V D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a c	ansaquente of							
60, be executed ician and burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a c	onsequence of							
Box 68760, eath certificate be exattending physician attending physician for use as the burial	<u>ea</u>		_ d	on boqueting of							
Box 687 eath certificate attending phys for use as the	/Med	IF FEMALE:	00-14						-71		
Records, P.O. Box 68760, — The law requires that the death certificate be executed atte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death	3 ☐Ectopic 5 ☐ Other (pregnancy (specify)				23d. Date of delive Month	ery Day Year
Division of Vital Records, P.O. for Attending Physicien: The law requires that the death. Director: Atten this certificate has been signed by the in by the funeral director, page 2 should be delached	y Ph	Part II. Other significant conditions of	ontributing to death but n	not resulting in th	ne underlying	cause given in	Part I.	23e. Did t	obacco	use contribute to th	e cause of death?
ord:								10	Yes 2	□Xio 3□ Prob	ably 4 □Unknown
Rec he taw e has t	Completed							24a. Was autor	an osy rmed?	prior to con	psy findings available inpletion of cause of
f Vital Re systeien: The tries is certificate had director, page	Be Co	25. Was case referred to medical examiner?				26	. Place of Death	1 🗘 Xes	2□ No		2□ No
of Vita Physicien: this certifice	္ရ	1X Yes 2 No 27. Manner of Death		2 ER/Outpa		OOA Other:	4 ☐ Nursing Hom	ne 5 ☐ Resid	dence	6 Other (Specify	At Scene
Vision (Attending F r death. ector: After by the funering	atlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye		now M	28c. Injury at Work? 1 ☐ Yes	2 XNo	8d. Describe 1	ī	ny occurred 255a.u.l. Fe	d
or Atte frer de Directo in by th	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury building, etc. (S	- At home, farm Specify)	, street, facto	ory, office	2	9f Location (Street an	d Number or Rural	I Route Number,
spitel nours a nerel C		29a. Certifier 1 ☐ Certifying Ph	vsician: To the best of m	oulcing	eath occurre	d at the time. d	ate and place a	Bal-	7 12	everi	anconia lav.
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: complately filled in by the	ledical	one) The control one	niner: On the basis of exa and manner stated	amination and/o	rinvestigatio	on, in my opinio	n, death occurre	d at the time,	date and	d place, and due to	the cause(s)
To with To con	Σ	29b. Signature and title of certifier	La o On	cs MA	A 2	9c. License nui OCME	mber			te signed (Month, L	Day, Year)
3		30. Name and address of person who	completed cause of death						-	26, 2005	
State	0	31. Date filed (Month, Day, Year)	32. egistrar's	Signature -	d 11	1 Penn	Street	Baltin	nore	, Marylan	d 21201
Registra			005 Julian	, Jr	porte						

JOHN CHRISTOPHER BOWLIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2105 30 05 /Medical 4a. Facility Name (If not institution, give street and number) Ab. City, Town, or Location of Death County of Death Examiner Bultionne Se 2000 If Under 1 Year 24 Hrs. Date of Birth (Month, Day, 7. Age (In yrs 8. Birthplace (State or Foreign Country), 6. Sex 5. Social Security Number **Funeral** Days Hours 241-52-603 1 □ M 200 F Months Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County Items 23a or 28e-f show other treumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Completed by Funeral Director ltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 32 21 22 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -American Indian, 11. Marital Status Black, White, etc. 2 No 1 ☐ Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 Divorced ac "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ont: If item 27 Is marked other than College (1-4or 5+) tome 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be P ဂ 19a. Informant's Name/Relationship (Type, Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md. 21229 20b. Place of Disposition (Name of Commetery, crematory of other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Pages Department of Importent: If it eny injury or o 12005 to Park 22. Name and Address of Facility
Joseph L. Russ Funeral Home, P.A.
2222 W. North Ave. Balto. Md. 21216 21. Signature of Funeral Service Licenses Duce. 23a. Part / anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a cons equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknow Š been signed be should be deta 23e. Did tobacco use convibute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown 2 **1** No 1 Yes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2∏ No 2 No 1 Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 ER/Dutpatient 2 1 Inpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) or of Death Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funerel Director: After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 2 Medical Exam 29d. Date signed (Month, 29c. License numbe Dav. Year) 29b. Signati 0 0

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Ye

(Item 23a) (Type, Print)

CO ORC VIII

trar's Signature

le

		•	1 - For State Registrer	State of Marylar		artment of H		Re	eg. No.	18429		
	Physici		1. Decedent's Name (First, Middle, Last) Elizabeth M. Barton		-	2. Date of Deat Month May 31,	Day Year 2005	3. Time of Death 06:15 a. M				
	/Medic Examin		4a. Fecility Name (If not institution, give s Good Samaritan Hos	4b. City, Town, or Baltimo	Location of Death		4c. County of Death	County of Death				
	Funeral Director		5. Social Security Number 6. Sex	<u> </u>	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, September	16, 1920 9. Birth	place (State or Foreign intrn) "Yland		
	aryland ehow dat	ľ	Usual Residence of Decedent 10a. State 10b. County Maryland N/A	10c. Ci	ty, Town or Lo					10d. Inside City Limits 1 X Yes 2 □ No		
	ith the Marylan or 28a-f ehow	Directo	10e. Street and Number		- Dai Cilio	10f. Zip Code		10	0g. Citizen of What Cou			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f ehow any folyury or other traumatic event, the Midical Examinar must be notified at ance.	by Funeral Director	3006 Fleetwood Avenue 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		21214 Was Decedent of Hilf Yes, specify Cuba 1 ☐ Yes 2 🕱 No	ispanic Origin? (Spe n, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	USA 14. Race - Amer Black, White Specify: Whi	, etc.		
21215-0036	Jwithin 72 hou jiene. r then "netura the Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		16a. Deced (Give life.		ation during most of workin)	ng	16b. Kind of Business/li Own Home	ndustry		
Maryland 2	iould be filed within Mental Hygiene. Parked other than natic event, IDE M	To Be C	17. Father's Name (First, Middle, Last) Scye Brodsky				18. Mother's Name Gertrude		Maiden Sumame)			
	and 2 should last and Men as Ith and Men n 27 is marke ier traumatic		19a. Informant's Name/Relationship (Ty) Elaine C. Pressley/Step			-	and Number or Rura Baltimore		City or Town, State, Zi 21206	p Code)		
Baltimore,	Pages 1 a nent of Hez int: If item iry or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	moval from State	Place of Dispo cemetery, crer stern Ce	esition (Name of matory or other plac metery	e) 6/3/		20c.Location-City or T Baltimore Mary			
Balti	permit. Departn Imports any Injk		21. Signature of Funeral Service License	· Christina L. H Yelton	ilton 27 5	Name and Address eonard J. R 305 Harford	s of Facility UCK INC I Road Balt	imore Mary	yland 21214			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A condition resulting in death) a										Approximate Interval Between Onset and Death		
400	ate be executed hysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to for as a consequested off.								
68760,	tificate b ig physic as the bi	ledica										
O. Box	The law requires that the death certificate be executed te has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown 2 St. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9							23d. Date of delivery Month Day Year		
م	quires that the signed by all be detacted.	by	Part II. Other significent conditions con	tributing to death but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute to			
l Records,		Completed						24a. Was ar autopsy perform 1 Yes 2	prior to co	oppsy findings available ompletion of cause of		
of Vital	Physiclan: this certificated director, I	Be	25. Was case referred to medical examiner? 1X Yes 2 □ No	ospital:	t=n/0.4-+:-	othe Othe	26. Place of Death					
	ting After fune	tion: To	27. Magner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at 2		nce 6 Other (Speci w injury occurred	ny)		
Division	at or Attendi s after death. Il Director: A d in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	reet and Number or Rur , State)	al Route Number,							
	To the Hospital within 24 hours a To the Funeral completely filled	Medicai C	29a. Certifier 1☐ Certifying Phys (Check only one) 2☐ Medical Exemin	ician: To the best of my known: On the basis of examination and manner stated.	an: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.							
	To ti Vithi Comp	W	29b. Signature and title of certifier	allan	ud	29c. License			June 1, 200	signed (Month, Day, Year) 1, 2005		
	5		30. Name and address of person who co	ALLAN	und	111 Pen	n Street	Baltimo	ore, Maryla	nd 21201		
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 2 200	32. Registrar's Signa	ature Los	ule						
DU	MH 17 Rev 1/2	201		10000	1							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2005 **Physician** Juanita R. Brooks 1:20a м 28 May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore 1204 Cord Street Middle River If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
July 8 1951 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 ☐ M 2X F MAryland 53 Yrs Director 213-58-4654 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Baltimore Middle River Directo MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Items 23a 1204 Cord Street 21220 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: SpecifyNhite Completed by 3 Widowed 4 XDivorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical permit. Pages 1 and 2 should be filed within 73.
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "nr any Injury or other traumatic event, Ite Media once. Elementary/Secondary (0-12) College (1-4or 5+) AT&T Administrator 4yrs 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Howard Booker Combs Dolores Milway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1204 Cord Street Baltimore MD Dolores Combs /mother 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Crematory Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee 300 Mace Ave. Baltimore MD 21221 Approximate Interval Between Onset and Decident 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List thiy one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Netastases Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical cell lung cancer Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transi that initiated events attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical use as the IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 2 No Hospital: 1 🗌 Inpatient 5 Residence 6 □ Other (Specify) 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide S Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

United Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifiei Medicai (Check only one) 29c. License number 29b. Signature and title of certifie D0025773 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1650 ORLEANS ST BALTIMORE, MD 2/23/ -OKA 31. Date filed (Month, Day, Year) JUN 0 2 2005 2. Registrar's Sigg State Registrar

	ı	4	1- State of Ma	•	artment of Health ar	nd Men	tal Hygie	200	5 1.8431	
	Physici	an	1. Decedent's Name (First, Middle, Last)	Bec	kman		2. Date of Death Month Day Year 10 10 10 10 10 10 10 10 10 10 10 10 10 1			
	/Medic Examin		4a. Facility Name (If right institution, give street and number)	11.001	4b. City, Town, or Location of	Death	ny o	4c. County of		
			5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday) A + MC	123 4 Hrs. 10 r	Date of Birth		Birthplace (State or Foreign	
	Funeral Director		5. Social Security Number 6. Sex 7. Age	13 Yrs.	Months Days Hours		Date of Birth Month, Day, Ye eb. 1, 1		MAryland	
	and **		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		•		10d. Inside City Limits	
	Maryl	tor	MD Baltimore	I	Middle River				1 □ Yes ŽŽNo	
	or 286	Direc	10e. Street and Number		10f. Zip Code		10g.	Citizen of Wh	at Country?	
	s 23a	rai	11 Marital Status 12. Was Decedent E	iver in ILS 12	Was Decedent of Hispania Origin	in? (Specify		SA 14 Bace	American Indian,	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mealleral Hygiene. If the 17 is marked other then "netural", or items 23e or 28e-f show other treumetic event. The Medical Example from the molified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		Was Decedent of Hispanic Origi If Yes, specify Cuban, Mexican, 1 ☐ Yes 2X No Specify:	Puerto Rica	n, etc.)	Black,	White, etc. White	
21215-0036	in 72 hou n "netura Asdical E	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occupation e kind of work done during most of DO NOT use retired)	of working	16b	. Kind of Busi	ness/Industry	
212	giene.	Com	Elementary/Secondary (0-12) College (1-4or 5-	Stud				Schoo		
	2 should be filed and Mental Hygis Is marked other sumetic svent, II	Be	17. Father's Name (First, Middle, Last) Joseph G. Beckman				rst, Middle, Maid			
LI Z	should lind Men	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street and Number		e Kear ute Number, Ci		ate, Zip Code)	
	1 and 2: Health ar em 27 is ther treu		Joseph Beckman /father		7 Cord Street					
altimore,	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State		osition (Name of matory or other place)	Date			ty or Town, State	
Iţi	- 문 원 등		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		2 Name and Address of Facility	6/1/0			lle MD	
ä	Deparing Department of the policy of the policy in the policy in the policy in the policy of the pol		1 Terry Conn	elly	300MaceAve.	salti Balti	ellyFu more _M	neral D 212	HomeofEssex 21	
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final		iter the mode of dying, such as ca		spiratory arrest,		Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	consequence of):	?e osteasarcom	- ~			2-705.	
	Examiner	_	Sequentially list conditions, if any, leading to immediate Due to (or as a	consequence of):						
	cuted id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c							
8760,	be executed sicien and burial-transit		resulting in death) Last Due to (or as a	consequence of):						
687	ficate I physics the b	edica	d							
). Box	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 m/onths? 1 □ Yes 2 □ No 9 □ Unknown	2 ☐ Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Month	,	
P.0	res that the de igned by the be detached		9 ☐ Unknown Part II. Other significent conditions contributing to death bu	t not resulting in the	underlying cause given in Part I.	1	23e. Did tobaco	o use contrib	ute to the cause of death?	
rds	w requires been sign should be	ed by	Notary of wholed myosance	0~9		_ []	1 🗋 Yes	2 No 3	☐ Probably 4 ☐ Unknown	
Records,	The law requate has been page 2 shoul	Completed					24a. Was an autopsy performed	pride dea	or e autopsy findings available or to completion of cause of ath?	
		O	25. Was case referred to medical		26. Place o		1 ☐ Yes 2 ☐ neck only one)	No IL]Yes 2□ No	
of V	d is	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatier			-	5 Residence			
		tion:	27. Manner of Death 1 Natural 5 Pending (Month, Day) 2 Accident investigation	Year) 28b. Time o	of 28c. Injury at Work? M 1 □ Yes 2 ▼No		Describe how in	ilary occurred		
Division	i or Attendi after death. Director: A in by the fu	Certification:	- Marini 6 Could get be	treet, factory, office	/			or Rural Route Number,		
	spitel	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of and manner stat	examination and/or in						
	To the Ho within 24 to To the Fu completely	Me	29b. Signature and title of certifier	- 0	29c. License number		29d.	Date signed (Month, Day, Year)	
	1		I Swed / M. R.; t	1.L.	17546	7		5/28/1	,	
1	11		and address of person who completed cause of de	PHD	Print)	te s	stre	+ BAI	tunore Mar lang	
	Sta Registr	-	31. Date filed (Month, Day, Year) 32. Registra 33. Registra	r's Signature	We .					

			Pleas	State of M						•	_	Die.	
			1 - For Stata Registrar	State of W	aryland	-	rtificate of		and wichte		. No. 20	05	181.32
			Decedent's Name (First, Middle,	Last)						te of Death			3. Time of Death
	Physici /Medic		Donald	Joseph	F	Belan;	ger, Sr.			y 23,	2005	Year	4:10PM M
4	Examin		4a. Facility Name (If not institution,	give street and number,)		4b. City, Town,	or Location of			4c. County	of Death	<u> </u>
			LaPlata Cente				LaP1a				Cha	rles	
	Funeral		, , , , , , , , , , , , , , , , , , , ,	6. Sex 7. Ag	ge (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Dat	e of Birth onth, Day, Y e 30,	ear)	9. Birthp	lace (State or Foreign htry)
	Director		398-01-7684 Usual Residence of Decedent	XX	87	113.			Jun	e 30,	1917	Wisc	consin
	/and		10a. State 10b. County		10c. City, 7	Town or Lo	cation					1	0d. Inside City Limits
	a-f st	tor	Maryland Prince	George's		Up	per Marl	boro					1 ☐ Yes 2 ☐XNo
7	or 28	Oire	10e. Street and Number	1 D1 1			10f. Zip Code	00770		10g	. Citizen of W		itry?
-	ain w	rai	5605 S. Marwoo				_i	20772			U.S		
	ltems Items	nne	11. Marital Status 1 □ Never Married 2 □ Marrie	12. Was Decedent Armed Forces: ad 1 Tyyes 2	7	- 1	Was Decedent of I f Yes, specify Cub		Puerto Rican,	es or No- etc.)		k, White,	
36	or or	by F	3 Newobi Wallied 2 Marile 3 Newobi Wallied 2 Marile 3 Divorced	If Yes, Give Year or Dates:	4011		1□Yes 2☑No	Specify:			Specify.	:	White
Ö .	be fled within 72 hours after death with the Maryland tal Hygiene. Ital Hygiene. do other then "neturel", or Items 23e or 28e-f show event, the Madical Examiner must be motified at	Completed by Funeral Director	15. Decedent' (Specify only highest			16a. Dece	tent's Usual Occu	pation	of working	16	b. Kind of Bu	siness/Inc	dustry
2	9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	npie	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work done DO NOT use retire	ed)	or working		π .		
2	tygier her th	Ö	12th 17. Father's Name (First, Middle, L	2	1	'ılm	Editor	19 Mothor	's Name (First,		Movies	01	
anc	ntal Hed of	Be c	Isaac Belange					Rose			iden Sumam	θ)	
2	Should Dd Me mark matic	70	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address (Street	t and Number	or Rural Route	Number, C	ity or Town,	State, Zip	Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Innportent: if them 271s marked other then "neturel; or Items 23e or 28e-f show any injury or other treumatic event, the Modical Examinar must be notified at once.		Donald J. Bela	nnger, Jr. ((Son)	117	6 Carrol	1 Road	Waldor	f, Man	ryland	2060)2
ore,	item		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	2	20b. Plac	e of Dispo	sition (Name of matory or other pla	100)	May 27,	20	c. Location -	City or To	wn, State
Ĕ.	ment of		'4 □ Donation 5 □ Other (Sp	a ∟Hemoval from State ecify)	Mary	land	Veteran	s Cem.	2005	Cl	neltenl	ham,	Maryland
alt a	permit. Departi Import any inj		21. Signuture of Funer I Sorvice L				. Name and Addre				al Home		
	<u> </u>		Josus O. A		0257							nton,	MD20735
102	4 66		232 Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final	only one cause on each I	ine.	A		ing, such as c	ardiac or respir	atory arrest	'		Approximate Interval Between Opset and Death
	nysician /Medical		disease or condition resulting in death)	_ a	a consequer		M EN3	,				4	Daroh
E	Examiner			1		NON	4 as	17/001	EUNS	CLE	ZODE	3 _.	4 years
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequer	rue ut).							-3
	and and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
760,	ate be executed nysician and he burial-transit	cai Ex	rossiting in south, East	Due to (or as	a consequer	ice oi):							
	physicate sthe			d						<u></u>			
Вох	nding use a	N/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Te				23d. Date	of delive	ry
m į	deair e atte ed for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a]Ectopic pregnand] Other (specify) _	y			Mon	nth	Day Year
о. О.	mar me death cerunical ed by the attending phy detached for use as th	by Physician/Med	9 🗍 Unknown		7 15 25 1						1		
<u>ග</u>	Attenuing Privateur; The law requires that the death Sertifica er death. Affer this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the	by I	Part II. Other significant condition	ns contributing to death t	out not resultin	ng in the u	nderlying cause gr	ven in Part I.	23				e cause of death? abiy \times Unknown
orc	requi	eted								-	1		
Records,	e law has b je 2 s	Completed							24	a. Was an autopsy performe	d? d	Vere autor rior to con eath?	psy findings available appletion of cause of
Vital	eicien; Ine law certificate has b irector, page 2 sl		OF Man ones referred to modical					00 Di-		Yes 2	No 1	☐Yes	2 □ No
=	s certi	To Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpati	ent 2∏EB	VOutpatien	t 3 DOA Ot		of Death (Chec sing Home 5		e 6 DOthe	r (Specify	•)
ָם ו ניין	grnye Ierthis Ieral di	T:u	27. Manner of Death	28a. Date of Inju	ury 28	Bb. Time of		ry at			injury occurre		,
0 1	andin sath. or: Af he fur	atic	1 Natural 5 Pending 2 Accident investiga	ation		,,]Yes 2□N	lo				
Division of	or Aut Iter di Nirect in by 1	Certification:	3 Suicide 6 Could no 4 Homicide determine	and 289. Place of In	jury - At home tc. <i>(Specify)</i>	e, farm, str	eet, factory, office		28f. Loc City	ation (Stree or Town, 5	t and Numbe State)	r or Rurai	Route Number,
<u>ا</u>	ours a		29a. Certifier 1 Certifying	Physician: To the best	of my knowle	edge death	occurred at the ti	ime date and	I place, and due	to the caus	a(s) and mar	ner as st	ated
	to the hospitel of attending Priyetcler; the within 24 hours after death, within 24 hours after death, to the Funerel Briector; After this certificate his completely filled in by the funeral director, page	edicai	(Check only 2 Medical E	xaminer: On the basis of and manner st	of examination	and/or in	estigation, in my	opinion, death	occurred at th	e time, date	and place, a	nd due to	the cause(s)
	vithin To the	M	29b. Signature and title of certifier	110	T 1		29c. Licen:	se number	2.0	29d.	Date signed		Day, Year)
			home	My x	1 00		1110	1063	4		112	3/())
	10+	1	(5 RUVU)	no completed cause of	ren	mo	Print)	100	RF.	mil	2	0 (0	03
	Sta Registr		31. Date filed (Month, Day, Year)	005 Régist	rar's Signatur	· Son	de						

			For State	State	of Marylar		artment of F		nd Mental Hy	100	005	186	33
			Registrar 1. Decedent's Neme (First, Middle	Last)			tineate of	Death	2. Date of De	Reg. No.		3. Time of D	eath
	Physici		Jacquelyn A		inante				Month May 28	Day 2005	Yeer	6:35	
	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, o	r Location of 0			nty of Deeth		
	- NO		Montgomery Hos	pice Cas	ey House	2	Rockvi	11e		Mon	tgome	C y	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 █ F	7. Age (In yrs.		If Under 1 Year Months Days		Hrs. 8. Date of Birl Min. (Month, Da	y, Year)	9. Birth Cou	place (Stete or i	Foreign
i Bra	Director		214-36-4133 Usual Residence of Decedent	12 W 2 (2)		7 Yrs.			May 1,	1938		ington,	
	land ow		10a. State 10b. County		10c. Ci	ly, Town or Lo	cation					10d. Inside City	Limits
	Many Many	tor	Maryland Montg	omerv	K	Censing	ton					1 Tes 2	2 ₩ No
	or 28g	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citizen o	f What Cou	ntry?	
	23a c	aic	lllll Brandywi	ne Stree	t		20895			Unite	ed Sta	ates	
	tema tema	nue	11. Marital Status	Armed I		.S. 13.	Was Decedent of H If Yes, specify Cubi	lispanic Origin an, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	14. A	ace - Ameri lack, White		
0000	s afte	by F	1 Never Married 2 Marri 3 Widowed 4 Divorced	ed 1 Yes If Yes, 0 Year or	2 XNo live		1 ☐ Yes 2 ☐ No	Specify:		Spec	ify: Wh	ite	
3	filed within 72 hours after deeth with the Maryland Hygiene. Ither than "natural", or items 23s or 28s-f show ent, Ita Medical Franc, or must be notified a		15. Decedent			16a. Dece	dent's Usual Occup	ation		16b. Kind of	Business/Ir	ndustry	
2	hin 72	Completed	(Specify only highes Elementary/Secondary (0-12)	1	() (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most o d)	of working			,	
7	giene giene er the	E O	11	Joneyo	(1 10, 51)		Bus	Drive	r	Priv	vate S	School	
	be file tal Hy d oth	Be (17. Father's Name (First, Middle, I						s Name (First, Middle,				
200	should be ind Mental I marked o	ပ္	John R. Peyto						nces Ameli				
	C1 10 - 61		19a. Informant's Name/Relationsh Edgar Gordon Bi		chand				o <i>r Rural Route Numbe</i> reet, Kens:				1895
D.	1 and Health Iem 27 other tr	18	20a. Method of Disposition	.556.07.110		-	sition (Name of matory or other place		Date	20c. Location			
	Pages nent of int: if it iry or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (St		II State		matory or other plac Cemetery	1	me 1, 2005				
Saltimor		- 1	21. Signature of Funeral Service I		pric.	21011	2. Name and Addre	ss of Facility	Robert A. Chase, Inc	Pump	ey Fu	neral li	ome/
מ	permit. Departr Imports any injt		1 any fr	RoBBi	MO1	.356 B	etnesda- ethesda,	Maryla	onase, inc	3501	Wisc	onsin A	venue
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the deat							Approximate Interval Between	9 9 n
94	Physician		Immediate Cause (Final disease or condition		etastati	c Care	inoma					Onset and De	
	/Medical Examiner		resulting in death)		o (or as a consec		LITORIA					OIIC_ICa	
	w f	_	Sequentially list conditions, if any, leading to immediate		reast Ca							Five Ye	ars
	ed isit	nine	cause. Enter Underlying Cause (Disease or injury	Due	(or as a conseq	puence or).							
	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	o (or as a conseq	juence of):					-		
5	w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	cai		d.									
	tificat ng phy as th	_											
X Q Q	th cer endin	an/N	IF FEMALE: 23b. Was decedent pregnant		utcome of pregnation		Ectopic pregnancy	,			ate of deliv	- /	
	a dea he att	Physician/Med	in the past 12 months? 1 ☐ Yes 2 🛣 No		gnant at time of c		Other (specify)			r	Aonth	Day Ye	ar
г Э	d by I		9 ☐ Unknown Part II. Other significant condition	as contributing to	death but not rec	ulting in the u	ndarhina causa an	en in Part I	23a Did te	abacco use co	otributa to t	the cause of dea	ath?
Š,	The law requires that the death certifica site has been signed by the attending ph bage 2 should be detached for use as it	1 by	Malignant Pl			iditing in the d	nounying cause gir	on arract.		res 2□No		babiy 4 🔀Un	- 1
Records	v requ	ompieted							24a. Was	20 24	Ware aut	opsy findings av	aulabla
Ž Ž	sicien: The law s certificate has b lirector, page 2 s	dwo	Anasarca						autop perfo	rmed?	prior to co death?	impletion of cau	
		O	25. Was case referred to medical					26 Place of	1 ☐ Yes 1 Death (Check only o		1 🗆 Yes	2 LI No	
<u> </u>	Physicien: this certific ral director.	To B	examiner? 1 ☐ Yes 2 ☐KNo	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 DOA Oth		ing Home 5 ☐ Resid		ther (Speci	y Hospi	ce
	ng Ph ter th neral		27. Manner of Death 1 Natural 5 Pending		e of Injury onth, Day Year)	28b. Time of Injury	28c. Injui Wor	y at	28d. Describe I				
SIO	Attending ir death. ector: After by the fune	catio	2 ☐ Accident investig	ation				Yes 2 □ No					
	or Atl	Certification;	3 Suicide 6 Could r 4 Homicide determine	200. Flat	ce of Injury - At h ding, etc. <i>(Speci</i> l	ome, farm, str (y)	eet, factory, office		28f. Location (5 City or Tox		nber or Run	al Route Numbe	≱ r,
_	pital ours a erel (29a. Certifier 1 ☐ Certifyin	n Physician: To ti	ne hest of my kno	wledge deat	h occurred at the tu	ne date and	place, and due to the	cause(s) and i	manner as s	etated	
	the Hospital hin 24 hours a the Funerel I npletely filled	Medicai	(Check only 2 Medical I	Examiner: On the	basis of examina	ation and/or in	vestigation, in my	ppinion, death	occurred at the time,	date and place	e, and due t	o the cause(s)	
	To the Hospital or Attending Physicien: Thin 24 hours stier death of the Funerel Director: After this certific Completely filled in by the funeral director.	Me	29b. Signature and title of certifier	0 1	2 2		29c. Licens	e number		29d. Date sign	ned (Month,	Day, Year)	
	X		6.6	· Li	love	MY	D094	70	1	May 29	2005	i	
1	7		30. Name and address of person	who completed ca	use of death (Iter	n 23a) (Type,	Print)						
	J		Eugene P. Libre	, M.D.,	10901 Cc	nnecti	cut Aven	ue, Ker	nsington, l	Marylar	nd 208	395	
	Sta Registi		31. Date filed (Month, Day, Year)	2005	Registrar's Signa	A April	ule						

××
Box 68760,
P.O.
rds,
Records, F
Vital H
n of Vi
ion
ivision

			Please Type or Print in Black Indelible State of Maryland / Department		•	_		
		_	1 - State Registrar Certificate	of Death	Reg.	71115	18434	
	° Physici /Medio		1. Decedent's Name (First, Middle, Last) Nancy Lee Bonaventure		2. Date of Death Month MAY	Day Year 28 Zooy	3. Time of Death	
	Examin			own, or Location of Death attimore		4c. County of Deat N/A	h	
	Funeral Director		190 40 0332 10 N 20 56 Yrs.	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country) 1949 Pennsylvania		
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Baltimore Catonsville				10d. Inside City Limits 1 ☐ Yes 2 No	
	with the sor 28a.	Direct	10e. Street and Number 10f. Zip C	21228	10g.	Citizen of What Co	puntry?	
36	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show carret Examiner must be millited at	by Funeral Director	6110 Regent Park Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDivorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 1 Yes 2 In Yes 2	ent of Hispanic Origin? (Spec fy Cuban, Mexican, Puerto R	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit		
21215-0036	I within 72 hou liene. r than "nature the Modical E	Completed	College (1-4or 5-)	Occupation done during most of workin a retired) ologist	16	Medical		
Maryland 2	12 should be filled within in and Mental Hygiene. 7 is marked other than "traumatic event, the Marken	To Be C	17. Father's Name (First, Middle, Last) John Baranchak	18. Mother's Name Ruth	(First, Middle, Mai Pelton	den Sumame)		
	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natur any linjury or other traumatic event, Ite W. Lical 2008.		Jennifer Bonaventure / Daughter 6110 Regen: 20a. Method of Disposition 1 Burial 2 Tormation 3 Removal from State	e of Da	Catonsv		yland 21228 Town, State	
Baltimore,	permit. P Departme Important any Injury		21. Signatur Tural Service Licenses 22. Name and 4001 Ri	Address of Facility Golitchie Highwa	nce Funer y Baltin	al Servio	ce, P.A.	
68760,	Examiner and prize the burial-transit	dicai Examiner	23a. Part 1. Enter the disease, or complications that caused the seath. Do not enter the mode shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it also teams of the cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last Due to (or as a consequence of): Cut to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	nA			Approximate Interval Batween Onset and Death 12 I TOURS	
P.O. Box 6	that the death certificate led by the attending physi detached for use as the I	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 3 □ Ectopic pregnant at time of death 9 □ Unknown			23d. Date of del Month	ivery Day Year	
	w requires that the been signed by th should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying call MITRAL STENOSIS	use given in Part I.			the cause of death?	
Records,	The law rec ate has bee page 2 shou	Completed	MITRAL REGURGITATION		24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of	
of Vital	Phyaician: this certitical	Be	25. Was case referred to medical examiner?	26. Place of Death		- 50.		
Division of	tter The	Certification: To	27. Manner of Death 1 Manuer of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year) 3 Suicide 3 Suicide 6 Could not be	Ic. Injury at 2. Work? 1 Yes 2 No	28d. Describe how			
Div	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely tilled in by the tu	al Certii	4 Homicide building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred a	at the time, date and place, a		e(s) and manner as		
	o the Ho vithin 24 l o the Fu ompletely	Medical	250. Oignature and the or control	in my opinion, death occurre		Date signed (Mont		
	+ 3 + 8		Puin W. Cho Surgeon	D41129	M,	47 28,2	005	
	.1)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PETER W. CHO, M.D. 2411 WEST BELVEDE RE	AVENUE, BALT	IMOR, MA	HIZYLAND	21215	
	Sta Registr		31. Date filed (Month, Day, Year) 2 2005 32. Registrar's Signature					

amend item#8, perFin, G845, 7/8/05 TT

State of Maryland 7 Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yea Physician Joseph Enoch Crowe, Jr. 12:20P M 2005 May 31 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 1743 Inverness Avenue Dunda1k Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 1932 (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours **™** M 2 F Yrs Director 212-30-3054 Mary land Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits me 23a or 28e-f show Dundalk 1 ☐ Yes 2 ☒ No Maryland Baltimore Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 United States death 1743 Inverness Avenue Funeral 7 is marked other then "naturel", or Iteme treumatic event, the Medical Examinations 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after Hygiene. XXYes 2 □ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Korean White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7 Years General Manager Seafood permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy importent: if tiem 27 is marked othe any linury or other treumatic event once, in 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Ellen Ehoff ဂ္ Joseph E. Crowe, Sr. 19a. Informant's Name/Relationship (Type, Print) (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Joseph E. Crowe, III 1743 Inverness Avenue Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Holy Rosary Cemetery 6/3/2005 nature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic **Physician** months adeno Carcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by å 1 Yes 2 No 3 Probably 4 Junknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 1 ☐ Yes 2 ☐ No 2 1 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 2 1 ☐ Yes 2 ☑ No 5 Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification; 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitei 24 hours 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 05 D45535

State Registrar Scot

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

2112 Dundalk

32. Registra s Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Feese

		1- For State of Maryland	Department of He Certificate of D	ealth and Mental Hy Death	/glene Reg. No. 2005 18436
Physic	ian	1. Decedent's Name (First, Middle, Last) Synthia R. Cunning		2, Date of De Month	eath 3. Time of Death
/Medi Examii Funeral Director		4a. Facility Name (If not institution, give street and number) FYANKIN SQUAVE HOSDIHAI Censor Social Security Number 6. Sex 7. Age (In yrs. last 1 M 2 M 74	Her Boseda	le	4c. County of Death BAILIMOX orth ab (Year) 930 West Virginia
D	7.	Usual Residence of Decedent 10a. State 10b. County 10c. City, T	own or Location Rosedale	, , , , , , , , , , , , , , , , , , , ,	10d. Inside City Limits
with the M 3s or 28s-f	I Director	10e. Street and Number 5352 Glen Thorne Court	10f. Zip Code 2123	37	10g. Citizen of What Country?
Iryland 21215-0036 should be filed within 72 hours after death with the Maryland of Mental Hygiene marked other than "natural", or Items 23s or 28s-f show matter event, the Medical Examinations to rutified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		spanic Origin? (Specify Yes or No h, Mexican, Puerto Rican, etc.) Specify:	o- 14. Race - American Indian, Black, White, etc. Specify: White
d 21215-0036 filed within 72 hours aff Hygiene. Hygiene "netural; or sther than "netural; or ent, the Medical Exami	Completed by	(Specify only highest grade completed)	6a. Decedent's Usual Occupa (Give kind of work done di life. DO NOT use retired) Personel Sec	uring most of working	16b. Kind of Business/Industry Dept. of Defense
€ data b	To Be C	17. Father's Name (First, Middle, Last) Oliver Heaster		18. Mother's Name (First, Middle Bessie Remle	
Mar rd 2 st lith ar 27 1s 1rau		19a. Informant's Name/Relationship (Type, Print) Karen Popp /daughter		nd Number or Rural Route Numb ngton Road Ba	per, City or Town, State, Zip Code) .ltimore MD
attimore, mit. Pages 1 ar spartment of Hea portent: If item; y injury or other		20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	e of Disposition (Name of stery, crematory or other place Densoffaith		20c. Location - City or Town, State Rossville MD
Baltimo permit. Pages Department of Importent: If is any injury or one		21. Signature of Funeral Service Licens 6		ce Ave. Balti	FuneralHomeofEssex more MD 21221
Physician /Medical-		23a. Part 1. Enter the disease, or complications that caused the dealer shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequent	mor recurre		Approximate Interval Between Onset and Death
cate be executed CA physician and CA the burial-transit CA PA	dicai Examiner	Sequentially list conditions b.	ce of):		
BOX 6 death certifi e attending	Physician/Med	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death	ath 3 ☐Ectopic pregnancy		23d. Date of delivery Month Day Year
S, F es tha gned se de	by	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause give		tobacco use contribute to the cause of death? Yes 2,⊠No 3 □ Probably 4 □Unknown
The ate h	Completed				
Of Vital Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2★No Hospital: 1★Inpatient 2☐ ER	Outpatient 3 DOA	26. Place of Death (Check only of 4 Nursing Home 5 Resi	
	Certification:	1. ★Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	b. Time of lnjury 28c. Injury Work 1 1 7	es 2 No	how injury occurred
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Affei completely filled in by the fune		4 Homicide determined 239. Place of Injury - Achome building, etc. (Specify)		City or To	
To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	dge, death occurred at the time and/or investigation, in my opi 29c. License	inion, death occurred at the time,	date and place, and due to the cause(s)
		29b. Signature and titte of certifies	XR	52379	29d. Date signed (Month, Day, Year)
101		30. Name and address of persola who completed cause of death (Item 23 Shirt and A. M.) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	9000 Franklin	Square Deive, T	Baltimore, MDZ1237
Regist	\$. 0	JUN 0 2 2005 June 14	Sparke		
	-001	OF	RIGINAL		

D			1 - State Unpend Item 2	State of Maryla 23a,pt.II,27	and/Depa per mee	rtment of F	lealth an Deatha	d Mental H s	lygien Reg. N	e .200	5	1010
	Physic /Med		1. Decedent's Name (First, Middle, Las Dinah Kim	t)				2. Date of I May 2	Death	3-11	'ear	3. Time of Death
5	Exami		^{4a.} Facility Name (If not institution, give Frederick Memoria	street and number) 1 Hospital		4b. City, Town, o Frederi			4	c. County of rederi	Death	
567	Funeral Director		5. Social Security Number 6. Security Number 212-80-2944	7. Age (In yi ☐ M 2♥ F 48	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of E Min. (Month, I March		0	. Birthpla Country	ace (State or Foreign y)
	Maryland a-f ehow	tor	10a. State 10b. County Md Carroll		City, Town or Loc kesville						100	d. Inside City Limits
	th with tha 23a or 28	ai Director	10e. Street and Number 2823 Old Libert	y Road		10f. Zip Code 21784			10g. C	itizen of Wha	at Country	
980	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I the standard and Mental Hygiene item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Modical Exertine matter retified at	by Funeral	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	lf .	/as Decedent of H Yes, specify Cuba	ispanic Origin n, Mexican, P Specify:	? (Specify Yes or Nuerto Rican, etc.)		14. Race -	White, et	tc.
Maryland 21215-0036	d within 72 ho jiene. r than "natu	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12	cation de completed) College (1-4or 5+)	(Give k	ent's Usual Occupa ind of work done of O NOT use retired ralegal	ation furing most of)	working	16b. l	Kind of Busin		
yland	2 should ba filed within and Mental Hygiene. Is marked other than aumatic event, ILEM.	To Be C	17. Father's Name (First, Middle, Last) Jack Lloyd Coll				Joann	Name (First, Middi 1e Sturgi	11			
	jes 1 and 2 sh of Health and If item 27 is π or other traum		19a. Informant's Name/Relationship (7) Curt S. Collins (20a. Method of Disposition 1 □ Burial 2 ▼Cremation 3 □ F	brother)	2823	Old Liber	cty Rd.	, Sykesv Date	ille		1784	
Baltimore,	permit. Pages 1 and 2. Department of Health as Important: If item 27 is any injury or other trau		21. Signature of Funeral Service Licens Puge 1 august	Al	22.	y Cremati	s of Facility H	-05 aight Fur esville,	nera	esvill L Home	е, М & С	d hapel
68760,	death certificate be exacuted By attending physician and derives as the burial-transit Cor use as the burial-transit	edical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause Enter Lindenthing Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection) Due to (or as a consection) Due to (or as a consection) Due to (or as a consection)	rphoses equence of):						1n	pproximate Interval Between Onset and Death
.O. Box	aath certif attending for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 🗆 E	ctopic pregnancy Other (specify)				23d. Date of Month	delivery Da	ay Year
Records, P.	nrequires that the de been signad by the should be detached	ted by Pl	Part II. Other significant conditions con Chronic Alcohol Al		sulting in the unc	erlying cause give	n in Part I.	nn.	tobacco i		e to the c	cause of death?
al Rec	Tha far ate has page 2	Completed by						24a. Was auto perfo 1 X Yes		prior	to compli 1?	findings available letion of cause of
Division of Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	To E	25. Was case referred to medical examiner? 127. Wanner of Death 127. Natural 27. Accident 3 Suicide 4 Hornicide 28. Pending investigation 4 Could not be determined	ospital: 1 ☐ Inpatient 2 ≥ 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - Athoulding, etc. (Special Control of the Control o	ER/Outpatient 28b. Time of Injury nome, farm, stree	3 DOA Other 28c. Injury Work M 1 Y	4 Nursing	Peath (Check only) Home 5 Resi 28d. Describe 28f. Location (City or To	idence how injur	y occurred d Number or		oute Number,
	e Hospital 24 hours e Funeral letely filled	Medical Co	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examin	sician: To the best of my kn ner: On the basis of examination	owledge, death o ation and/or inve	occurred at the time stigation, in my opi	, date and pla nion, death oc	ce, and due to the curred at the time,	cause(s) date and	and manner	as stated	d. e cause(s)
)	To the within To the compl		29b. Signature and title of certifier Pamer Lycutha	U. MO		29c. License			29d. Dat May	e signed (Mo 25, 2	onth, Day	', Year)
			30. Name and address of person who co Pamela E. Sau	thall, MD		111 Penr	Stree	t Baltin	nore,	, Mary	land	21201
	Sta Registra		31. Date filed (Month, Day, Year) 2 20	32. Angistrar's Sign	ature /	and to						

		1 - State Registrar				Ce	ertificate	e of De	eath		Reg. No.	. 00	U	10400
/sicia	an	1. Decedent's Name (First, M	fiddle, La	ist)				0 - 1		2. Date of Month	Death Day 27	,	Year	3. Time of Death
ledic	al	Gladys			E.			Colem.		May		County of	005	12:57P
amin	er	4a. Facility Name (If not institute 508 Dogwood			umoer)		, ,	inthi		eatii		Anne		nde1
eral		5. Social Security Number	6. 9	Бөх		rs. last birthday) If Under Months		Under 24 Hours	Hrs. 8. Date of Min. (Month,	Birth Day, Year		9. Birthp	lace (State or Forei
tor		214-46-0723		1□M 2፟ØF	93	Yrs.	Wionins	Jays ,	10015	5-23	19 12")			MD
	-	Usual Residence of Deceder 10a, State 10b, Co			10c.	City, Town or L	ocation						1	0d. Inside City Limit
	tor	MD Ann	e Ar	unde1		Linthio	cum							1 ☐ Yes 2X N
)irec	10e. Street and Number					10f. Zip	Code			10g. Cit	izen of Wh		ntry?
	ral	508 Dogwood	Roa					2109		- 12		US		
	Funeral Director	11. Marital Status 1 Never Married 2 📉	Married	Armed F	cedent Ever in orces? 2 X No	10.5.			nic Origin Mexican, P	? (Specify Yes or tuerto Rican, etc.)	No-		, White,	an Indian, etc.
	þ	3 Widowed 4 Divo		If Yes, G Year or	ive		1 ☐ Yes 2	2 ₫ No . 5	Specify:			Specify:	whit	e
	Completed	15. Dec	edent's E)	16a. Dece	edent's Usua e kind of wor DO NOT us	al Occupation	n ng most of	working	16b. Ki	ind of Bus	iness/Ind	dustry
١	mple	Elementary/Secondary (0-	· · ·		(1-4or 5+)		oo not us Iomemal	-			Hor	me Ow	mer	
١		12 17. Father's Name (First, Mic	idle. Last	t)					. Mother's	Name (First, Mid	dle, Maiden	Sumame)	
	To Be	William C.							В	lanche A	. Cana	арр		
l	-	19a. Informant's Name/Rela					•			r Rural Route Nu			tate, Zip	Code)
	J,	Mr. William	Cole	man/hus					d, Li	inthicum				
1	1	29a Method of Disposition 1 Sourial 2 Crema	tion 3	∃Rjemoval from		o. Place of Disp cemetery, cre ew Cath		ne of ther place)	61	Date 1/05		cation - C		
		4 □ Danation 5 □ Oth			141			ud Addronn o		•		11tim		
		21. Bignatule of Pullerar Ser		()	3.6	-	. Z. IVa:110 ali	iu Audi 635 C	aracility	Singleto	n Fune	eral	Home	P.A.
			E / I / R	7.	M	01364	Secon	nd Ave	SW	Glen Bur	nte Mi	1 210	61	
ı		art1. Enter the disease	e, or com	nplications that	caused the de	1	Seco	nd Ave	= SW	Glen Bur	nie M	210	61_	Approximate
n al er		shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	e, or com List only	a. Due to	caused the de each line.	equence of):	nter the mode	ind Ave	uch as car	Gien Bur rdiac or respirator	nie Mi y arrest,	, 210	061	
	cal Examiner	shock, or heart failure. Immediate Cause (Final disease or condition	e, or com List only	a. Due to Due to	caused the de each line.	eath. Do not en	nter the mode	ind Ave	uch as car	Glen Bur rdiac or respirator	nie Mi y arrest,	, 210	061	Approximate Interval Between
	dicai	shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e, or com List only	a. Due to	caused the de each line.	equence of):	nter the mode	ind Ave	uch as car	Gien Bur rdiac or respirator	nie Mi y arrest,	, 210	061	Approximate Interval Between
	dicai	shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	List only	a. Due to c. Due to d. 23c. If yes, or	caused the de each line.	pequence of): equence of): equence of): equence of):	nter the mode	e of dying, s	uch as car	Glen Burrdiac or respirator	rie Mi	, 210	of delive	Approximate Interval Between Onset and Death
	Physician/Medical	shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 Yes 2 2 30	List only	b. Due to c	caused the de each line. o (or as a cons o (or as a cons o (or as a cons o tutcome of precipint 2 Figurant at time on nown	paath. Do not er sequence of): sequence of): sequence of): sequence of): sequence of):	Decorate the mode	e of dying, s	c M	Gien Bur diac or respirator	arrest,	23d. Date Month	of delive	Approximate Interval Between Onset and Death 1 1 1 1 20 9 7
	by Physiclan/Medical	shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 Yes 2 Vo 9 Unknown	List only	b. Due to c	caused the de each line. o (or as a cons o (or as a cons o (or as a cons o tutcome of precipint 2 Figurant at time on nown	paath. Do not er sequence of): sequence of): sequence of): sequence of): sequence of):	Decorate the mode	e of dying, s	c M	Gien Burrdiac or respirator	arrest,	23d. Date Month	of delive	Approximate Interval Between Onset and Death 1 177 20 97 Party Day Year The cause of death?
	by Physiclan/Medical	shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 Yes 2 Vo 9 Unknown	List only	b. Due to c	caused the de each line. o (or as a cons o (or as a cons o (or as a cons o tutcome of precipint 2 Figurant at time on nown	paath. Do not er sequence of): sequence of): sequence of): sequence of): sequence of):	Decorate the mode	e of dying, s	c M	Gien Burrdiac or respirator Con BCI The Co	d tobacco u	23d. Date Month	of delive	Approximate Interval Between Onset and Death 1 1 7 0 9 7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	by Physiclan/Medical	shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 Yes 2 Vo 9 Unknown	List only	b. Due to c	caused the de each line. o (or as a cons o (or as a cons o (or as a cons o tutcome of precipint 2 Figurant at time on nown	paath. Do not er sequence of): sequence of): sequence of): sequence of): sequence of):	Decorate the mode	e of dying, s	c M	Cien Burrdiac or respirator Compact Co	d tobacco ulas an utopasy differenced?	23d. Date Month	of delive	Approximate Interval Between Onset and Death 1 1 7
	Physician/Medical	shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 Yes 2 Vo 9 Unknown	List only	a. Due to b. Due to c. Due to d	caused the de each line. o (or as a cons o (or as a cons o (or as a cons o tutcome of precipint 2 Figurant at time on nown	paath. Do not er sequence of): sequence of): sequence of): sequence of): sequence of):	Decorate the mode	e of dying, s	uch as car	23e. D 24a. W 24a. W 24a. W 24a. W 24a. W 24a. W 24a. W 24a. W 24a. W 24a. W	d tobacco under the property of the property o	23d. Date Month	of delive	Approximate Interval Between Onset and Death 1 1 1 2 0 9 7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	To Be Completed by Physiclan/Medical	shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 Yes 2 0 0 Unknown Part II. Other significant context of the cast of	List only	a. Due to b. Due to c. Due to d	caused the de each line. o (or as a consider of prepared to the consider of prepared to the consider of prepared to the consider of prepared to the consider of prepared to the consider of prepared to the consider of prepared to the consider of prepared to the consider of prepared to the consider of prepared to the consider of the consideration of	pancy etal death 5 in the control of	Ectopic prediction of the control of	e of dying, s egnancy egnancy ause given i	uch as car	23e. D 24a. W 24a. W 24a. W an p Death (Check on	d tobacco of the same and topacco 3d. Date Month	of delive h oute to th I Prob ere auto or to cor ath? Yes	Approximate Interval Between Onset and Death 1 1 7 1 7 1 7 1 7 1 1 7 1 1 1 1 1 1 1	
	To Be Completed by Physiclan/Medical	shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions are referred to me examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pa	List only	a. Due to b. Due to c. Due to d	caused the de each line. o (or as a consider of prepared to the consider of prepared to the consider of prepared to the consider of prepared to the consider of prepared to the consider of prepared to the consider of prepared to the consider of prepared to the consider of prepared to the consider of prepared to the consider of the consideration of	peach. Do not er pequence of): peq	Ectopic prediction of the control of	e of dying, s e of dying, s egnancy ecify) ause given i	uch as car	23e. D 24a. W 24a. W 24a. W 24a. W 24a. W 24a. W 24a. W 24a. W 24a. W 24a. W	d tobacco of the same and topacco 3d. Date Month	of delive h oute to th I Prob ere auto or to cor ath? Yes	Approximate Interval Between Onset and Death 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
	To Be Completed by Physiclan/Medical	shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1	List only	Due to Due to Due to Due to Due to Due to A Due to Due to Due to A Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to	caused the de each line. o (or as a consider of or as a consider of or as a consider of or as a consider of or as a consider of or as a consider of or as a consider of or as a consider of or as a consider of or as a consider of or as a consider of or as a consider of or as a consider of or as a consider of or as a consider of or as a consider of or as a consider of or as a consider or as a consider of or as a consider or as a	panth. Do not er sequence of):	Ectopic pre Other (spe	e of dying, s e of dying, s egnancy ecify) ause given i Other: 8c. Injury at Work? 1 □ Yes	n Part I.	23e. D 23e. D 24a. W p 1 Ye Death (Check on regions) 28f. Locatio	d tobacco of the same of the s	23d. Date Month	of deliver h pute to the surface autopior to cor ath?	Approximate Interval Between Onset and Death 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	o Be Completed by Physiclan/Medical	shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1	List only addical addical addical	Due to Due to Due to Due to Due to Due to A Due to Due to Due to A Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to	caused the de each line. (or as a consider of or as a consider of or as a consider of or as a consider of or as a consider of or as a consider of or as a consider of or as a consider of or as a consider of or as a consider of or or or or or or or or or or or or or	panth. Do not er sequence of):	Ectopic pre Other (spe	e of dying, s e of dying, s egnancy ecify) ause given i Other: 8c. Injury at Work? 1 □ Yes	n Part I.	23e. D 23e. D 24a. W p 1 Ye Death (Check on regions) 28f. Locatio	d tobacco under the state of tobacco under the s	23d. Date Month	of deliver h pute to the surface autopior to cor ath?	Approximate Interval Between Onset and Death 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	Certification; To Be Completed by Physician/Medical	shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1	adical anding vestigation betermined	a. Due to b. Due to c. Due to d	caused the de each line. O (or as a consider of or as a consider or as a	pequence of): dequence DEctopic prediction of treet, factory	e of dying, s e of dying, s egnancy ecify) ause given i OA Other: Work? 1 Yes r, office	uch as car uch as car n Part I. Part I. Nursin 2 No	23e. D 23e. D 24a. W p 1 Ye Death (Check on regions) 28f. Locatio	d tobacco use as an an an an an an an an an an an an an	23d. Date Month see contribution 3 24b. We pring the definition of the contribution o	of deliver to the suite to the suite to the suite to the suite condition of the condition o	Approximate Interval Between Onset and Death 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
	ertification: To Be Completed by Physiclan/Medical	shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1	adical anding vestigation betermined	a. Due to b. Due to c. Due to d	caused the de each line. O (or as a cons O (or as a con	pequence of): dequence Dectopic production of Metreet, factory	e of dying, s e of dying, s egnancy ecify) ause given i OA Other: Work? 1 Yes r, office	n Part I.	23e. D 23e. D 1 24a. W an Popular (Check on 1 28d. Descri 28f. Locatio City or	arrest, arr	23d. Date Month 23d. Date Month 3 24b. We pride 1 5 Other y occurred d Number place, and manning place, and manning place, and manning place, and manning place is a second control of the second co	of deliver h oute to the pute to the pute to cortain to cortain to cortain the cortain th	Approximate Interval Between Onset and Death 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
	edical Certification; To Be Completed by Physiclan/Medical	shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1	adical anding vestigation betermined	a. Due to b. Due to c. Due to d	caused the de each line. O (or as a consider of or as a consider or as a	pequence of): dequence Dectopic production of M and treet, factory at the occurred annestigation, 29c.	e of dying, s e of dying, s egnancy ectify) ause given i 26 0A Other: Work? 1 □ Yes 7, office at the time, in my opini	uch as car uch as car n Part I. Part I. Part I. Nursin 2 No date and pon, death of	City or at the tin	arrest, arr	23d. Date Month 23d. Date Month 3 24b. We pride 1 5 Other y occurred d Number place, and manning place, and manning place, and manning place, and manning place is a second control of the second co	of deliver h oute to the pute to the pute to cortain to cortain to cortain the cortain th	Approximate Interval Between Onset and Death 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 18439 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 25 2005 12:30 P M May IRIS YVONNE CAMPBELL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 493 Winterberry Drive Edgewood If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 1□M 2QF 43 May 8, Illinois Director 352-54-4236 1962 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-1 show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State rai', or itams 23a or 28a-1 show Examiner must be notified at Edgewood 1 ☐ Yes 2 No Maryland Harford Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 493 Winterberry Drive 21040 USA Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. TYes 2 ☐ No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Department of Defense Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Athalia Yvonne Anderson Vance Leon Steward, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 493 Winterberry Drive, Edgewood, MD 21040 James Michael Campbell/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 6/1/05 Rantoul, IL Eden Park Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1317 Cokesbury Road, Abingdon, MD 21009
Complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A.

Approximately F.A Marke T-23a. Part1. Enter the disease. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** BARAST Metastatic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner metastatic CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or). Examine The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?

1 Yes 2 No Month Year 4 Pregnant at time of death 5 Other (specify) the a detached 9□ Unknown à s baen signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Mellitus 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No 2 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Residence 6 Other (Specify) 1 🗌 Yes Certification: To this funeral Manner of 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide City or Town, State) within 24 hours a To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ne and address of person of death (Item 23a) (Type, Print) Kink USAHC. Murekota 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 2 2005 Registrar

			For	State of Marylan				•		_	10110
			1 - State Registrar		Cer	tificate of	Death		Reg. N	CUU 2.	18440
П	Physici	an .	Decedent's Name (First, Middle, Las. \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	t)				2. Date o		ay Year	3. Time of Death
	/Media		John Doc	dds				Mai			
Ì	Examir	er	4a. Facility Name (If not institution, give	. /	. 10	4b. City, Town,		4c. County of Death			
			Johns Hopkins				Itimor			N/A	
п	Funeral		5. Social Security Number 6. Se	DM a□E	last birthday) Yrs.	If Under 1 Year Months Days		Min. (Month	, Day, Year	r) Co	hplace (State or Foreign nuntry)
	Director		273-56-3432 'S Usual Residence of Decedent	50				Feb.	25,1	955 Ohi	0
	rland ow		10a. State 10b. County	10c. Cit	y, Town or Lo	cation		-			10d. Inside City Limits
	Many	tor	Maryland Balti	imore			ъ	Rosedale			1 ☐ Yes 2 🙀 No
	r 288	Director	10e. Street and Number	LINOIC		10f. Zip Code		OSECATE	10g. C	itizen of What Co	untry?
	h with	O E	6807 Apt. B Gold	den Ring Road		21	237			Unit	ed States
	deat	ner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13. V	Vas Decedent of	Hispanic Orig	in? (Specify Yes o Puerto Rican, etc.	r No-	14. Race - Ame	rican Indian,
စ္	after or ite	F	1 Never Married 20 Married	1 ☐ Yes 2 💢 No If Yes, Give		Yes 2X No		, Puerto Alcari, etc.	,	Black, White	A
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or items 23e or 28e-1 show the Medical Exat mat trust be traitled at	Completed by Funeral	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			opecny.			Specify:	White
5	72 h 'nett	ete	15. Decedent's Edi (Specify only highest grad	ucation de completed)	(Give	ent's Usual Occu kind of work done	during most	of working	16b.	Kind of Business/	Industry
2	vithin ne. han	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retin					
i N	lled v tygie her t		12 Years 17. Father's Name (First, Middle, Last)		Su	pervisor		's Name (First, Mic		raham Pa	ckaging
anc	be find here	Be	John V. Dodds, Sr	•						n Sumame)	
ž	d Mei mark natic	^c	19a. Informant's Name/Relationship (T		10h Maille	- Add (Case		ose DiCo		T 04-4- T	7-0-4-1
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23s or 28s-1 show with injury or other treumatic event, Item Medical Examinations Item without an once.		Tracey L. Dodds	(Wife)		Apt. B		r or Rural Route No n Ring Po			, MD 21237
	1 and Healt em 2 ther		20a. Method of Disposition			sition (Name of	Jorde	Date	-	Location - City or	
Baltimore,	in it of or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ I	Removal from State	emetery, cren	atory or other pla	1				
퍜	t. Partmer		4 Donation 5 NOther (Specify,			the same of the same of the same of the same of		6/2/2005	Ro	osedale,	Maryland
Bal	permi Depa Impo eny ir		21. Schature of Funeral Service Licens		D1	. Name and Addr 1da – Ruck	Funer	al Home	of Dur	ndalk, I	nc.
			23a. Part1 Enter the disease, or comp	aul				Dundalk		yland 2	1222
ļ,		4	sheck, or heart failure. List only o	one cause on each line.	n. Do not ente	er the mode of dy	ing, such as c	ardiac or respirato	ry arrest,		Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	a Pancreatic	Can	261					
	/Medical Examiner		Todaling in doubly	Due to (or as a conseq	uence of):						
		-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq.	uence of)-						
	ted Isit	nin	Cause (Disease or injury	220 (0 (0) 00 000000	401100 017.						
	xecu and	Examiner	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):						
760,	Attending Physicien: The law requires that the death certificate be executed rideath. sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	calE		9							
687	icate phys			d							
×	certii nding use a	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna						23d. Date of deli	iverv
Вох	atte	ciai	in the past 12 months?	1 Live birth 2 ☐ Feta 4 Pregnant at time of d		Ectopic pregnant Other (specify)	СУ		_	Month	Day Year
o.	the c y the achec	ysi	9 Unknown	9□ Unknown							
٥.	res that the death certifica igned by the attending ph be detached for use as th	by Physician/Med	Part II. Other significant conditions co	intributing to death but not res	ulting in the ur	derlying cause g	iven in Part I.	23e. [oid tobacco	use contribute to	the cause of death?
rds	quires n sign							1	☐ Yes 2	2 □ No 3 □ Pr	obably 4 Onknown
Records,	w requir s been si should	jete						24a. V	Vas an	24b. Were au	topsy findings available
Be	he la e has age 2	Completed	-					_ p	utopsy erformed?	prior to death?	completion of cause of
	ifficat or, pa	O e	25. Was case referred to medical				26 Place	of Death (Check or		o 1 Yes	2 □ No
>	/sicie s cert direct	To B	ovaminar?	Hospital: 1 Inpatient 2	ER/Outpatien	3 DOA O		sing Home 5 F		6 □Other (Spec	rific)
Division of Vital	y Phy er this	<u>-</u> :-	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Inju	ary at			ary occurred	ary)
0	nding tth. r: Afte	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		ork? ∃Yes 2.⊟N	lo			
S	Attendir death	iffice	3 ☐ Suicide 6 ☐ Could not be determined	289. Place of injury - At no	ome, farm, stre	et, factory, office)				ral Route Number,
è	el or A s after il Dire	Certification:	4 Homicide	building, etc. (Specify	7)			City of	Town, Stat	(0)	
)	To the Hospitel or Attending Physicien: The law Within 24 hours after death. To the Funerel Director: After this certificate has completely illed in by the funeral director, page 2		29a. Certifier 1 Certifying Phy	vsicien: To the best of my kno	wledge, death	occurred at the t	ime, date and	place, and due to	the cause(s) and manner as	stated.
	ne Ho ne Fu ne Fu	Medical	(Check only 2 ☐ Medicel Exem one)	iner: On the basis of examina and manner stated.	tion and/or inv	estigation, in my	opinion, death	h occurred at the ti	me, dat <i>e a</i> r	nd place, and due	to the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier				se number	_		ate signed (Month	
	2/		Asen	es MD		2	301	0	1	Day 3	0,2605
1-	10/		30. Name and address of person who c	ompleted cause of death (Item	23a) (Type, I	Print)		LIT O	7011	11 - 1	0,2605 her Jones MD
V	(t. ,		4940 East	ern Avenu	e Bo	altim	ove, I	MD 21	224	Heat	ner Jonesmu
1	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Agna 0 2 2005	ture	· hair	K. J				
	Registr	ar	JUN	UZ ZUPO BREE	فكتر مستكاي	4004					

DHMH 17 Rev 1/2001

) <u>.</u> ()	2)		For	State of Maryla				•	_							
			1 - State Registrer		Ce	rtificate of D	eath		g. No. 4 U U	5 18441						
Н	Physicia	an	1. Decedent's Name (First, Middle, Last) Anthony Dixon					2. Date of Death Month	Day Yes							
	/Medic	al				41 63. 7		May	26 200							
	Examin	er	4a. Facility Name (<i>If not institution, giv</i> e s University of Maryl		Contor	4b. City, Town, or L Baltimo:			4c. County of D	eath V/A						
	Funeral		5. Social Security Number 6. Sex			If Under 1 Year	If Under 24 Hrs.	8. Date of Birth								
ь	Director			M 2□F 26	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 07–15–197	8 Ma	Birthplace (State or Foreign Country) ryland						
	D		Usual Residence of Decedent	10- 0	. T											
	shov	ž	10a. State 10b. County MD NA	106. C	ity, Town or Lo Ba	altimore				10d. Inside City Limits 1 Yes 2 No						
	the M	Director	10e. Street and Number			10f. Zip Code		10	og. Citizen of What							
	with Se or	חַר	1508 W. Fayette Stree	t Ant A		2122	3		USA	Country						
	death ms 2;	by Funeral		12. Was Decedent Ever in I Armed Forces?	J.S. 13.	Was Decedent of His If Yes, specify Cuban,	panic Origin? (Spe	ecify Yes or No-		merican Indian,						
9	or Ita	Fur	1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 M.No If Yes, Give		f Yes, specify Cuban, 1 □ Yes 2X No	Mexican, Puerto	Rican, etc.)	Black, W	hite, etc.						
93	ural',		3 Widowed 4 Divorced	Year or Dates:		1 1 1 es 2 2 1 1 1 0	эрөспу.		Specify: I	31ack						
7	filed within 72 hours after death with the Maryland Yeyjene. Yeysiene "natural", or Itams 23e or 28e-f show ant, I've Medical Evair inclined to indiffed at	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dece	dent's Usual Occupati kind of work done du DO NOT use retired)	ion ring most of worki	ng 1	16b. Kind of Busine	ss/Industry						
12	withir ene. than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		borer			War	ehouse						
d 2	filed withi Hygiene. other ther	Be C	17. Father's Name (First, Middle, Last)				8. Mother's Name	(First, Middle, N	faiden Sumame)							
<u>lar</u>	uld be Aenta rked ric av	To B	Marion Dixon				Stepha	nie Owens								
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene it from 27 Is marked to Hygiene "natural", or Itams 23e or 28e-f show from 27 Is marked than "natural", or Itams 12e, notified at	. 2	19a. Informant's Name/Relationship (Type			ng Address (Street an				e, Zip Code)						
	1 and 2 Health tem 27 other tr		Stephanie Owens/ Mother			W. Fayette S										
Baltimore,	ges 1 au it of Hea if item or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R	emovar nom State	_	sition (Name of natory or other place)			20c. Location - City							
Ħ	permit. Page Department o Important: If any injury or once.		' 4 □ Donation 5 □ Other (Specify)			-	,	J5 J.	ansdowne, r	'W						
Ba	permit. Pages Department of h Important: If its any injury or of		21. Signature of Pulleral Service License	Mt. Zion Cemetery 06-03-05 Lansdowne, MD Signature of Funeral Service Licensee Wylie Funeral Home 638 N. Gilmor St. Baltimore, MD 21217												
			23a. Part1. Enter the disease, or complishock, or heart failure. List only on	F	1					Approximate						
	Pnysician	g - m	Immediate Cause (Final	HULTIPLE		FORCE				Interval Between Onset and Death						
	/Medical		disease or condition resulting in death)	Due to (or as a conse		TURLE	1103010	100								
И	Examiner		Sequentially list conditions.		-11731											
<i></i>	pe is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Universitying Cause (Disease or injury	Due to (or as a conse	quence of):											
Ψ	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	. Due to (or as a conse	quence of):											
760,	te be executed ysician and ie burial-transit	calE		·	, ,											
189	death certificate b attending physic															
Вох	andin use	In/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet		Ectopic pregnancy			23d. Date of	delivery						
	ed for	sicla	in the past 12 months?	4 Pregnant at time of 9 Unknown		Other (specify)			Month	Day Year						
P.0	that the de ed by the a detached	Physiclan/Med	9 Unknown					00- 0:44-		. A. H						
ŝ	as ng	by	Part II. Other significant conditions con	induting to death but not re	suiting in the u	nderiying cause given	in Paπ I.			to the cause of death? Probably 4 Unknown						
Records,	w require been si should I	Completed														
Rec	The law ate has page 2 :	mp						24a. Was an autopsy perform	prior	autopsy findings available to completion of cause of ?						
Vital		e Co	25. Was case referred to medical				26. Place of Death	12 Yes 2		es 2 No						
>	Physicien: this certific ral director,	OB	examiner?	ospital: 1XXInpatient 2[ER/Outpatier				nce 6 Other (S	necify)						
οl		T:U	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		at 2	28d. Describe how	w injury occurred							
Sio	Attending or death. ector: After by the fune	atlc	1 Natural 5 Pending 2 Accident investigation	5126105	10:00		s 2 No	USTECT V	MAS ASSA	AVLT ETD						
Division	irecter of the point of the poi	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, str ify)	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or State)	Rural Route Number,						
	pitel c		00 Carties 1 Cartifying Phys	CORRECTION	_	FACILITY	(C 2CV 2 2 C	1 1 - 20	1 110						
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☑ Medical Examir	sicien: To the best of my kn ner: On the basis of examin and manner stated.	ation and/or in	n occurred at the time vestigation, in my opir	, date and place, a nion, death occurre	and due to the car ed at the time, da	use(s) and manner te and place, and c	as stated. lue to the cause(s)						
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License		29	ld. Date signed (Mo	onth, Day, Year)						
	. > - 0		> One D			OCM	E		May 27,	2005						
	1		30. Name and address of person who co	,	em 23a) (Type,											
				VB10 HI)	III Penn	Street	Baltimo	re, Maryl	and 21201						
	Sta Registr		31. Date filed (Month Pay, Year) 200	32. egistrar's Sign	ature	ander										
	riegisti			-	- 19											

			St 1 - State Registrar	ate of Marylan	d / Depa		of He	ealth a		ental Hyg		005	18442
			1. Decedent's Name (First, Middle, Last)							2. Date of Deat Month	h Day	Year	3. Time of Death
)	Physici /Medio Examin	al	Charles Franklin 4a. Facility Name (If not institution, give stree		r	4b. City, 1	own, or	Location o	f Death	May	27	2005 ounty of Deat	5:15 P M
			Gilchrist Center At	GBMC		Tow					Ba	altimo	re
	Funeral		5. Social Security Number 6. Sex 1213-46-1174	7. Age (In yrs. 2 59		If Under Months	1 Year Days	If Under 2 Hours	Min.	Date of Birth (Month, Day)	Year)	9. Birth	nplace (State or Foreign untry)
	Director		Usual Residence of Decedent	33						Mar. 5,	1940	6 Wes	t Virginia
	how		10a. State 10b. County	10c. City	y, Town or Lo	cation		-					10d. Inside City Limits
	ours after death with the Marylan rel', or Items 23e or 28e-f show Examiliner mat be notified at	Director	Maryland Harford	E	dgewoo								1 □Yes 2⊕No
	with the		10e. Street and Number			10f. Zip				1	0g. Citizer	of What Co	untry?
	leath	Funeral	1719 Judy Way 11. Marital Status 12. V	as Decedent Ever in U.	S. 13. V		10.40		in? (Spe	city Yes or No-		SA Race - Ame	rican Indian.
9	or Iter		1 ☐ Never Married 2 Married 1	med Forces? ☐ Yes 2X No					, Pu <i>è</i> rto I	city Yes or No- Rican, etc.)		Black, White	e, etc.
003	72 hours after death with the Maryland neturel', or Items 23e or 28e-f show Jical Examiliar out be multified at	d by	3 ☐ Widowed 4 ☐ Divorced	Yes, Give ear or Dates:		1 □ Y <i>e</i> s 2	X NO	Specify:			Sp	ecify:	White
15-(lete	15. Decedent's Education (Specify only highest grade con		16a. Deced	dent's Usua kind of wor DO NOT us	k done di	uring most	of worki	ng	16b. Kind	of Business/l	ndustry
21215-0036	d within giene. Ir then "	Completed	Elementary/Secondary (0-12) C	ollege (1-4or 5+)		od Se				H	ast I	Food R	estaurant
שָׁל	Hyge H	Be C	17. Father's Name (First, Middle, Last)					18. Mother		(First, Middle, I	Aaiden Su	mame)	cocactare
ylar		70 E	Charles Meridith D	eHaven				Thel	ma	Marie	Vand	Mark	
Maryland	2 sh and Is m		19a. Informant's Name/Relationship (Type, F Brenda Lee DeHaven -	•		-				d, Mary			
	s 1 and if Health item 27 other tr		20a. Method of Disposition	20b. P	lace of Dispo	sition (Nam	e of			_		ion - City or 1	
JOL.	Pages nent of H int: If ite iry or of		1 Burial 2 ☐ Cremation 3 ☐ Removed 4 ☐ Donation 5 ☐ Other (Specify)		emetery, crer Chris				6/01	/2005			
Baltimore,	교 된 본 급 .	1	21. Synchure of Funeral Service Licensee	1) 1	22	. Name and	Address	s of Facility	/	-			
ä	Depa Impo any is	7 1	Ally Milma	stellet	MC 13	Comas 17 Col	Fun cesbi	eral urv R	Home	P.A.	on N	arvla	nd 21009
Е			23a. Part1. Enter the disease, or complication shock, or hearn failure. List only one ca	ns that caused the death use on each line.	n. Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory arre	est,	LLY LC	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	Metastatic	Ling	Cance	r						Onset and Death MONTUS
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):								
		er	Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):		-						
V	outed Id ansit	Examiner	Cause (Disease or injury that initiated events										
0	be executed sician and burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):								
8760,	icate by physical s the bu	dlcal	d										
x 68	death certificate e attending phys d for use as the	/Me	IF FEMALE: 23c. If	yes, outcome of pregna	ncv						204	Date of dall	
Вох	death atten	clan	in the past 12 months?	Live birth 2 Fetal	Ideath 3□	Ectopic pre					230	. Date of delive Month	Day Year
Ŏ.	at the de by the a tached	Physiclan/Med	9 Unknown	Unknown									
S, P	as this gned be de	by P	Part II. Other significant conditions contribu	-	-		-	n in Part I.					the cause of death?
ord	w requir been si shoutd	ted	Chronic Obstru	five Pulmoni	ary l)iJeas	e_	-		1 □ Ye	s 2 🗆 N	lo 3 Pro	bably 4 🗆 Unknown
Vital Records,	he law e has b ige 2 sl	ompleted								24a. Was ar autops perforn	/		opsy findings available ompletion of cause of
a		e Col	OF Was appropriate modical							1 ☐ Yes 2	No No	1 🗆 Yes	2 No
Ş	Physicien: this certific ral director,	OB	25. Was case referred to medical examiner? 1 □ Yes 2 No Hospi	tal: 1 Inpatient 2	ER/Outpatien	t 3 DO	Other			(Check only on ne 5 ☐ Reside		Other (Spec	in Hospice
ιof		n: T	27. Manner of Death 28	la. Date of Injury (Month, Day Year)	28b. Time of		lc. Injury Work	at		8d. Describe ho		*	(), () () () () () () () () () () () () ()
Sior	Attending r death. ector: After by the fune	atlc	1 Natural 5 Pending 2 Accident investigation	(,,	,,	М		es 2 🗆 N	10				
Division	l or Atten after deat Director: I in by the	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28	le. Place of Injury - At he building, etc. (Specify	ome, farm, str /)	eet, factory,	office		2	8f. Location (St. City or Town		umber or Rui	ral Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dire completely filled in b	0	29a. Certifier 1 Certifying Physician	1: To the best of my kno	wledge, death	Occurred a	t the time	e, date and	place a	nd due to the ca	use(s) and	d manner as	stated
	e Hos Pe Fur	edical	(Check only 2 Medical Examiner:	On the basis of examination of manner stated.	tion and/or in	estigation,	in my opi	inion, death	h occurre	d at the time, da	ite and pla	ce, and due	to the cause(s)
	To th withir To th comp	M	29b. Signature and title of certifier			29c.	License	number				gned (Month	
			how Had	MO				51199					1005
	n		30. Name and address of person who comple	ted cause of death (Item	23a) (Type,	Print)	10	h	7 / 3		395	n Ble	ack M-i)
	Sta	te	31. Date filed (Month, Day, Year) JUN 0 2 2005	Registrar's Signa	ture	no/e	141	/	12	07		-	20
	Registr		30. Name and address of person who comple 660 1 Nor R Cha. 31. Date filed (Month, Day, Year) JUN 0 2 2005	Elever B	400	2)		_					

De Haven, Charles 5-27-05(2) 515 pm

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician Agnes Mary Davis 2005 June 1. 7:00 A.M /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner 800 Candlelight Drive, Apt. 2C Harford If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Yeer) Birthplace (Stete or Foreign Country) **Funeral** Months Days Hours 1□ M 2□XF Yrs. Director 216-09-1249 Feb. 10. 1916 Maryland Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours effer death with the Meryland nent of Health and Mentel Hygiene.
ant: If Item 27 is marked other than "natural", or items 23s or 28s-f show ury or other traumetic event, the Medical Experiment and a position and the position of the profiled at 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Locetion r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 No Directo Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 21014 800 Candlelight Drive, Apt. 2C United States Funerai Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: ģ 3 to Widowed 4 □ Divorced White Completed 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 -0-Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Fialkowski unknown Mary unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 800 Candlelight Drive, Apt. 2C, Bel Air, MD Robert M. Davis (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory June 2, 2005 Baltimore, Maryland 21. Signature of Funeral Service Licensee Brian T. Chisholm Funeral Services of Dulaney Valley P.A. 200 E. Padonia Road, Timonium, MD 23a. Pert1. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner to (or es a consequence of): Physician/Medical Examine ettending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Due to for as a consequence of) Kulin signed by the el Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy Completed After this certificate has funeral director, page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 28c. Injury et Work? 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 27. Menner of Deeth Certification: 1 Natural 5 Pending 1 Yes 2 No investigetion death. Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) À 4 - Homicide To the Hospital or within 24 hours eff To the Funeral Di completely filled in 1 Certifying Phyeicfan: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. edical 29a. Certifier (Check only 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) D 31464 MD 30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

Baltmore

Anite 208

DHMH 16 Rev 6/95

State

Registrar

SHOA113

31. Dete filed (Month, Dey, Year)

A. HASITMI

JUN 0 2 2005

821 N. EUTAW

32. Registrer's Signeture

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 10b per fh 2844 6-2-05 vt
State of Maryland / Department of Health and Mental Hygiene 2 [] [] 5 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Ma **Physician** 0200 A KODNEY Evans /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CATONSVILLE 5920 OLD FREDRICK ROAD BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Ol 30 - 1963 9. Birthplece (State or Foreign Country) MD 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1**™**M 2□F 220.92.4861 Director Usual Residence of Decedent 10d Inside City Limits 10b. County Baltimore 10a, State 10c. City, Town or Location and Mental Hygiene. Is marked other than "natural", or Items 23s or 28s-f show raumatic event, the Maxical Examiner must be notified at 1 ☐ Yes 2 No CATONSVILLE CATONSVILLE Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ROAD 5920 OLD FREDRICK Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 M Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) RETAIL CLERK 121H GRADE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be DOROTHY SINGLETON HOWARD EVANS ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21043 19a. Informant's Name/Relationship (Type, Print) 3004 NORTH RIDGE RD # CEO2 ELLCOT CTY, MD
Date 20c, Location - City or Town, State Department of Health ar Important: If item 27 Is any injury or other trau DOROTHY EVANS (MOTHER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 06.06.05 BALTO. ND MOODLAWN * 4 ☐ Donation 5 ☐ Other (Specify) VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL' PIKE, BALTO. MO 21229 permit. 21. Signature of Funeral Service Licensee CLL Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Adult Immuno Difficiency Syndrome year Physician /Medical Due to (or as a consequenca of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Physiclan/Medical the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Š 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. PP 1 Yes 2 No 3 Probably 4 Nnknown cate has been signage 2 should b Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No certificate has 1 Yes 2 No Be 26. Place of Death Check on one funeral director. 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: A 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number telelle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Trimble Hill CT. Lutheru; Mil; tello MD 6 31. Date filed (Month Day, Year) 32 Registrar's Signature JUN 0 2 2005 Registrar

	1 - For State C	of Maryland / Department of Certificate	of Health and Mental I of Death	Hygiene 2001	5 1841
ysician Medical caminer	1. Decedent's Name (First, Middle, Last) RUSSELL C. 4a. Facility Name (If not institution, give street and not	EDD7	2. Date of Month who, or Location of Death	Day Year 3 1 200 4c. County of Dea	
neral ector	HALBOA HOSPI 5. Social Security Number 220-20-8306 Usual Residence of Decedent	7. Age (In yrs, last birthday) If Under 1 Y	rear If Under 24 Hrs. 8. Date of Month, FEB.		RE CITY thplace (State or For
notified at	10a. State 10b. County MD ANNE ARUNDEL 10e. Street and Number	GLEN BURNIE	ode	10g. Citizen of What C	10d. Inside City Lin 1 ☐ Yes 2 📉
sample must be notified by Funeral Director	Armed F	2.XTNo ive 1 ☐ Yes 2.XT	t of Hispanic Origin? (Specify Yes or Cuban, Mexican, Puerto Rican, etc.	USA 14. Race - Am Black, Whi Specify:	
n, the Madical E.	15. Decedent's Education (Specify only highest grade completed, Elementary/Secondary (0-12) Cotlege	16a Decedent's Usual O	fone during most of working etired)	16b. Kind of Business	,
sumatic even	17. Father's Name (First, Middle, Last) ROY EDDY 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (S	18. Mother's Name (First, Mic SARAH INEZ JO treet and Number or Rural Route Nu	HNSON	Zip Code)
Important: Illient 27 is marked other train haudar, or trains 23 or costs anow any injury or other traumatic event, the Madical Examinar must be notified at once. To Be Completed by Funeral Director	JEANNE E. EDDY / WIFE 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from 4 Donation 5 Other (Specify) 21. Signature of Funer Service License	State 20b. Place of Disposition (Name cometery, crematory or other CHESAPEAKE CREM 22. Name and A	JUNE 3,	20c. Location - City of STEVENSVIL	Town, State LE, MD AVE. S.W.
iclan dical niner	TA	caused the death. Do not enter the mode of each line. JD - STAGE EM (or as a consequence of):	f dying, such as cardiac or respirato	ry arrest,	Approximate Interval Betweer Onset and Deat 7EARS
atending physician and for use as the burial-transit	cause. Enter Underlying Cause (Disease or injury that initiated events c.	(or as a consequence of): RONARY ARTE (or as a consequence of):		E	YEARS
etached for use as the	in the past 12 months?	utcome of pregnancy birth 2 Fetal death 3 Ectopic pregr nant at time of death 5 Other (specin		23d. Date of de Month	olivery Day Year
b b	Part II. Other significant conditions contributing to			Oid tobacco use contribute t Yes 2 □ No 3 □ P	o the cause of death
page 2	OF Was see referred to medical		a p	utopsy prior to death? es 2500 1 2 Yes	
al di	27. Manner of Death Statural 5 Pending 28a. Date (Mo.) 2 Accident investigation 28b.	nth, Day Year) Injury M	Work? 1 ☐ Yes 2 ☐ No	Residence 6 Other (Spe ibe how injury occurred	
To the Funeral Lifector: After completely filled in by the funer Medical Certification		e of Injury - At home, farm, street, factory, of ding, etc. (Specify) e best of my knowledge, death occurred at to basis of examination and/or investigation, in		on (Street and Number or Fi Town, State) the cause(s) and manner a	
completely filled in	(Check only one) 2 Madical Examinar: On the and ma 29b. Signature and title of certifier MGUSHC	rner stated. 29c. L	my opinion, death occurred at the tii icense number PQA P1871P	29d. Date signed (Mon	th, Day, Year)
State	30. Name and address of person who completed cau MILEN A A. GEBSK 31. Date filed (Month, Qay, Ygar)	ise of death (Item 23a) (Type, Print) HARBOR HOSP Begistrar's Signature	1TAL, 3001 S	HAMOVER S	ST, BALTIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 6.08 Quo5 A M nan /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospin BANTIMONE MINERSILY If Under 1 Year | If Under 24 Hrs.
Months Days | Hours | Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2□ F Months Yrs 34 Director 235 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b County 10c. City, Town or Location 10d. Inside City Limits 10a State or 28e-f show other traumetic event, the Medical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director BAI LIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3/6 21223 U5.A Items 23e MUNRUE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giv 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Warried 1☐ Yes 2€No ŏ Baltimore, Maryland 21215-0036 Specify. 3 Widowed 4 Divorced Black "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ENPERVISIX MAINTENANCE 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Forton N nichand Thinks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If itam 27 is eny injury or other trac 21223 316 BAIL MERS MO 5+ vonothe toutern N. MONRUE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 2 c. Location - City or Town, State 1 Burial 2 Teremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Kunerie BALFIMONE MD 21213 51 atucu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final isease Physician COTOMORY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner (esebruyus culan Secuentially list and tions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit End Sterace

Due to (or as a consequence of): Sno 68760. ab etes Box (IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy the atter in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Dav 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 Yes 2 No 3 Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? 2 1 No 1 ☐ Yes Division of Vital To the Hospital or Attanding Physician: director, 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes /2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mann of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 1 atural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 24 hours a Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai within 24 hor To tha Funs completely f (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 31/2005 752749 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

2 HIRGARD

Marked

Street, Bergman

South

istrar's Signature

60)

W.S

DHMH 17 Rev 1/2001

	1 01102		1 - State Unpend Item 2:					Mental Hy	giene 2005	818		
			Registrar 1. Decedent's Name (First, Middle, Last			ertificate of	Dealii	2. Date of De.		3. Time of Death		
н	Physici	an	KAREN LESLEY	FORCE				MAY 31		3:55 P M		
	/Medic Examin		4a. Facility Name (If not institution, give 10209 SUNNY LAKE	street and number)		4b. City, Town, COCKEYS	or Location of De		4c. County of Deatl)		
9	Euparal		5. Social Security Number 6. Se		(In yrs. last birthda	y) If Under 1 Year	If Under 24 H			nplace (State or Foreign		
	Funeral Director			TM OFFE	+O Yrs	Months Days	Hours Mi	March 6	$\frac{7}{1965}$ Nort	h Carolina		
	/land		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits		
	Marie 1	ior	Maryland Baltimo:	re	Cockey	sville				1 ☐ Yes 2 X No		
	or 28	je.	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	untry?		
	ath w	la	10209 Sunnylake F		. J		030		U.S.A.			
	er de	Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 1	 Was Decedent of I If Yes, specify Cub 	Hispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 14. Race - Arnel Black, White			
36	rs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:		Specify: Wh	iite		
9	72 hours after death with the Maryland natural', or llams 23a or 28a-f show dical Examinar must be incitiled at	ed	15. Decedent's Edu	reation	16a. De	cedent's Usual Occu	pation		16b. Kind of Business/			
21215-0036	within 7. ene. than "n	ple	(Specify only highest grad	e completed) College (1-4or 5+)	life	ive kind of work done b. DO NOT use retire	nd)					
21	filed with Hygiene. Ither thai	Completed		4 years	Direc	tor of Sales			Medical Ec	uipment		
nd	be file	Be	17. Father's Name (First, Middle, Last)						Maiden Surname)			
3	should be ind Mental markad c	To	Judson Franklin Fo		105.14	ilina Address (Chan	Glend		Slough	in Conto		
Maryland	d 2 sho th and i		19a. Informant's Name/Relationship (T)	(Lat.	Her /	Overlook			er, City or Town, State, 2 Maryland 2			
	Health tem 27 other tr		Judson Franklin For 20a. Method of Disposition	orce, or.	20b. Place of Dis	sposition (Name of		Date	20c. Location - City or			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Itams 23a or 28a-1 show any injury or other traumatic evant, the Madical Examinat must be notified at once.		1 ☐ Burial 2 【ACremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)		1	riematory`or other pla ount Crema	.	-3-05	Baltimore,	Marvland		
atti	permit. Page Depertment of Important: if any Injury or once.		21. Signature of Funeral Service Licens	00	or con in							
m	9 9 7 8 9		George J. Fer	rani		22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212						
			23a. Part1. Enter the disease, or composhock, or heart failure. List only o	ne cause on each line	١.	enter the mode of dyi	ng, such as card	ac or respiratory ar	rrest,	Approximate Interval Between		
	Priysician		Immediate Cause (Final disease or condition	lixed Drug	(Zo1pide	n,Zopiclon	e)Intox	ication C	omplicated	by Onset and Death		
	/Medical Examiner		resulting in death)	Drowning a	consequence of):							
		ان	Sequentially list conditions,	b. Dee to (or as a	consequence of):							
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
oʻ	be executed sician and burial-transit	Exa	resulting in death) Last	Due to (or as a	consequence of):							
3760,	3 % 6	cal		d								
68 3	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as t	Physician/Med	IF FEMALE:						1			
Box	ath ce	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal death	3 Ectopic pregnanc	y		23d. Date of deli Month	very Day Year		
	ires that the death signed by the atte d be detached for	ysic	1 ☐ Yes 2 ☐ No 9 ☑ Unknown	4□Pregnant at ti 9□Unknown	me or death	5 ☐ Other (specify) _						
P.O.	that the by detail		Part II. Other significant conditions co	ntributing to death but	not resulting in the	underlying cause gr	ven in Part I.	23e. Did to	obacco use contribute to	the cause of death?		
Records,	quires n sigr	ed by						1 🗆 1	Yes 2 X No 3 ☐ Pro	bably 4 Unknown		
000	aw requir s been si 2 should	olete						24a. Was	an 24b. Were au	opsy findings available		
R	ysician: The tav is certificate has director, page 2	Completed							rmed? death? 2 □ No 1 ☑ Yes	ompletion of cause of 2□ No		
Vital	ician: Th certificate ector, pag	BeC	25. Was case referred to medical examiner?				26. Place of D	eath (Check only o				
of V	Physician: this certific ral director,	P	1X Yes 2 No	Hospital: 1 Inpatient		Herit GL DOX			dence 6XXX ther (Spec	ity) SCENE		
n c		lon:	27. Manner of Death 1 □Natural 5 □ Pending	Found h. Day	Year) Found	Wo	ryat irk?]Yes 2 1 X∏No	Subject	now injury occurred took overdo ions and dro	se qf		
Division	or Attending after death. Diractor: Aftel in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	5-31-05 28e. Place of Injur	y - At home, farm,	street, factory, office	163 2110			ral Route Number, Inny Lake P1		
Ö	Dir.	Cert	4 Homicide	Found in		e		Cockevs	ville, MD	inny Lake Pi		
	To the Hospital or Atten within 24 hours after deat To the Funeral Diractor: completely filled in by the	edical (29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of ner: On the basis of e and manner state	examination and/o	eath occurred at the ti investigation, in my	ime, date and pla opinion, death oc	ce, and due to the	cause(s) and manner as date and place, and due	stated. to the cause(s)		
	Mithin Mithin Yearspl	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed (Month	, Day, Year)		
	(pul)		Dard Ha	elan 1	ud	OCM	Ε		JUNE 1, 20	05		
.0	1100		30. Name and address of person who co	ompleted cause of dea	ath (Item 23a) (Ty	pe, Print)						
	1	1	/ AD A > 11 Am	1 -1 -1		111 5	- a.		3.5	1 01001		
	Sta	ite_	31. Date filed (Month, Day, Year) JUN 0 2 200	LAO W 3. Registrar	's Signature	111 Per	nn Stree	t Baltin	nore, Maryla	nd 21201		

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 10b.c.d per Th 8844 6-2-05 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 2:15 AM 29 CHARLOME EVELYN GEBHARD 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MANOR KNOLLW00D 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Funeral 1 M 2 F 216.44.7201 58 PA Director Usual Residence of Decedent Anne Arundel Oc. City, Town or Location 10b. County 10d. Inside City Limits 10a State 28a-f ehow other treumetic event, the Medical Exartiner nust be notified at Brooky1n BALTIMORE 1 Xos 2 XNo Director Mb 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 609 BISCAY AVENUE 21225 USA Items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 ö 1 Yes 2 No Specify: Specify: WHITE à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: ie marked other then "neturei', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 1H GRADE College (1-4or 5+) SORTER BANKING MAIL 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental H IRENE YENSER PAUL WILLIAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lepartment of Health as Importent: If item 27 te eny injury or and TRACY GEBHARD SON 609 BISCAY AVE. BROOKLYN, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State GREENMOUNT 06.02.05 BALTO. MD ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licent VAUGHN C. GREENE FUNERAL SERVICE an 5151 BAUTO, NATU PIKE, BAUTO, MO 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart eilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Tyocardia weeks /Medical Duato (or as a consequence of) **Examiner** erebro Vasca Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of/s Examiner Hetastatic burial-transit Due to (or as a consequence of) attending physician P.O. Box 68760 Physician/Medical as the IF FEMALE: esr 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year ģ in the past 12 months? 1 ☐ Yes 2 🛣 No Day 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 1 Yes To the Hospital or Attending Physicien: within 24 hours after death.
To the Funerel Director: After this certified Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 K Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2 🔭 No ဂ္ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel L 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29b. Signature and title of contrier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene St Site # Si4B33 Baltimore HANNA 225 VAOER MID 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

IUN 0 2 2005

BHAV

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 19a per fh 9844 6-2-05 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month .Ourse GREGORY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HOSPITAL SPECIALTY BALTIMORE UNIVERSITY SALTIMORE If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2**Ø**F 220.H.26A7 85 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-1 show amy injury or other traumatic event, the Medical Examinar must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No NIA BALTIMORE Funeral Directo MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 2035 NORTHEAST 21227 AVENUE 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Bfack, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status l □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK Completed by 3 AWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOME MAKER DOMESTIC 101H GRADE NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MALLIN MILLIAM MCCOY SARAH COLEMAN ဥ 19a. leformaet's Name/Relationship (1909, Print) Barbara Brown (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AVENUE 1712 CARROLL BALTO CARROLL MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) CEDAR HILL 06.03.05 BALTO . MO 21. Signature of Funera Service Licensee 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATE PIKE, BALTO. MO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HEARI CONGESTIVE HONTH /Medical Due to (or as a consequence of): Examiner LETERIOSCLEROTIC CARRIOVASCULUR 126.13 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Disele Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by ARRELL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this certificate has been Autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? (RESPIRATORY FAILURE YNEU HOW Sta BACTEREN 1 AYES 22 NO Afte.
ar death.
virector: After this ceru..
the funeral director, pr 1 Tyes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Mpatient Cther: 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Naturaf 2 Accident 5 Pending 1 ☐Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours a To the Funaral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1346 SOUTH CHARLES 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 611 JANES Hynnus. University Specialty petral BALTIMONER 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JUN 0 2 2005 Registrar

			1 - For State Registrar	State of	Marylan		artment rtificate			and M	lental Hy	giene	11115	18451
	Discosio:		1. Decedent's Name (First, Middle,			_					2. Date of De Month	eath Day	Year	3. Time of Death
	Physici /Medio			Lelia I	ucille	Goetz	inger						2005	2:50 P ^M
	Examir		4a. Facility Name (If not institution,		nber)		4b. City,		Location of	of Death		4c.	County of Dear	
			6939 German Hil						dalk				Balti	
	Funeral		,	S.Sex 1 M 2 M F I	7. Age (In yrs. I	last birthday) Yrs.	If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Bi (Month, D	ay, Year)	9. Bird	thplace (State or Foreign ountry)
	Director		219-07-2296 Usual Residence of Decedent		88	113.					June 4	,191	6 Wes	t Virginia
	land Sw		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Many f sh	Ď	Maryland Ba	ltimore					r	unda	n T 1e			1 ☐ Yes 2 No
	28a	rec	10e. Street and Number	TCIMOTE_		-	10f. Zip	Code		Juna	ATK	10g. Citiz	zen of What Co	ountry?
	3a or	D	6939 German H	ill Road					2	1222	2	IIn	ited St	ates
	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show dical Examinat must be notitied at	Funeral Director	11. Marital Status	12. Was Dece	dent Ever in U.	S. 13.	Was Deced	ent of His			ecify Yes or No Rican, etc.)		14. Race - Ame	erican Indian,
9	or ite	F	1 Never Married 2 Marrie	Armed Ford	2X No		it Yes, spec 1 ☐ Yes 2			, Puerto	Rican, etc.)		Black, Whit	e, etc.
93	ral',	l by	3XXWidowed 4 ☐ Divorced	If Yes, Give Year or Da	ites:		ILI Yes 2	ZEJ NO	Specify:				Specify:	White
21215-0036	72 h 'natu	Completed	15. Decedent's (Specify only highest			16a. Dece	dent's Usua kind of wor DO NOT us	l Occupa k done d	tion uring most	t of work	ing	16b. Kir	nd of Business	Industry
12	vithin ne. han	mpi	Elementary/Secondary (0-12)	College (1-	-4or 5+)									
2	filed within Hygiene. other than " ent, the Me		8 Years 17. Father's Name (First, Middle, L.	2041		Но	memak		10 Matha	ala blama	e (First, Middle	-	wn Home	
anc	I be find hotal Head of	Be									na Hans		Sumame)	
ž	should be fand Mental I	^L	William Vana			10h Maili	A	(0)					- T Ct-t- 1	7: 0:11
Maryland	C) 10 -= 03		19a. Informant's Name/Relationshi Sharon Kasprzyk		hter)		-					-	Town, State, 2 Marylan	
	permit. Pages 1 and 3 Department of Health important: if item 27 any injury or other tr. once.		20a. Method of Disposition	(lace of Dispo					Date		cation - City or	
Baltimore,	Pages nent of h ant: if ite		1 XBurial 2 ☐ Cremation		State C6	emetery, crei	natory or ot	her place		1/20	205			
計	permit. Pag Department Important: i any injury o		* 4 □ Donation 5 □ Other (Special Service)			ak Law								, Maryland
Ba	permit. Departn imports any inju		1/2/	M									dalk, I	
			23a. Part. Enter the disease, or c	omplications that ca	used the death	Do not ent	922 Wi	ise .	Ave.	Dı cardiac (indalk,	_Mary	yland	21222 Approximate
ų.			shock, or heart failure. List of Immediate Cause (Final	nly one cause on ea	ich line.			,						Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. ///	eta Sta	772	COIC	Inc	mon	(uns			
н	Examiner			o) of eucl	or as a consequ	ience or):					/			
		ē	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (c	or as a consequ	uence of):								
	sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
Ć.	exec in an	Еха	resulting in death) Last	Due to (c	or as a consequ	uence of):								
8760,	ate be ex hysician the buria	dicai		d										
9	The faw requires that the death certificate be executed tte has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	edi									_	- 17		
Вох	death certifica attending ph d for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregnar		Textons are					2	3d. Date of del	ivery
	deat e attr	icia	in the past 12 months? 1 2 Yes 2 No	4□Pregna	ant at time of de		Ectopic pre Other (spe						Month	Day Year
P.0	at the de by the a tached	hys	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno	wn									
	signed I	by F	Part II. Other significant condition	s contributing to dea	ath but not resu	ulting in the u	nderlying ca	iuse give	n in Part I.		23e. Did	tobacco us	se contribute to	the cause of death?
pro	w require been si should I	ed	COPO								M	Yes 2	□No 3□Pr	obably 4 🗆 Unknown
of Vital Records,	has be	Completed	Celonoli	1 alte	nd1	cease	21				24a. Was		24b. Were au	topsy findings available
Ä	icate ha	E O		,	/							ormod? 2 No	death?	completion of cause of
ta	certifica rector, p	Be	25. Was case referred to medical						26. Place	of Death	(Check only	-4-		
\	d is	2	examiner? 1 □ Yes 2 No	Hospital: 1 □ In	patient 2 🗆 E	ER/Outpatier	t 3 🗆 DO	A Othe	r: 4 🗆 Nu	rsing Ho	me 5 Resi	idence 6	Other (Spec	cify)
0	ding Ph h. After th funeral		27. Manner of Death Natural 5 Pending	28a. Date of (Month	f Injury n, Day Year)	28b. Time of	28	3c. Injury Work	at		28d. Describe	how injury	occurred	
0	Attendii death. ctor: A y the fu	catl	2 Accident investiga	tion			М	1 🗆 Y	es 2□N	No				
Division	i or Attending after death. Director: After i in by the fune	ertification;	3 Suicide 6 Could no 4 Homicide determin	ad 286. Place	of Injury - At hor g, etc. (Specify	me, farm, str	eet, factory,	office		1	28f. Location (City or To			ral Route Number,
Ω	To the Hospital or Attentwithin 24 hours after deati To the Funeral Director: completely filled in by the	O												
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	(Check only 2 Medical E	Physicien: To the to caminer: On the base										
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifier	and mann	er stated.		290	License	number			29d Date	signed (Mont)	Day Vand
	T W S	1	134	1	1		1	105	-6-			() ()	signed (Montl	Day, 10al)
	-1		· runde	- /w	urv	7	0	183	7/			4/	2110	5
1	18		30. Name and address of person w	no completed cause	of death (Item	23a) (Type,	Print)	11	1.1	اخد	Sil	1	1127)
(Y		31. Date filed (Month, Day, Year)	1/h (1)	gistrar's Signat	// (UPI	11/0	aci p	AJIC	1110	+	1001	/
	Sta Registr	- 200		2 2005	of death (Item	H.	Gossel	المرية						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death ^{Day}2005 Month **Physician** 2:45a 28 Clara Elizabeth Gartrell May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Apr 15 1918 Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🔯 F 213-60-8775 Mď Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show d other then "natural", or Itams 23a or 28a-f shov event, the Medical Examiner must be notified at Md Carroll Sykesville 1 TyYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3 Obrecht Road 21784 Funerai Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status ☐Yes 2t7 No Yes, Give X 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: þ white 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic markad other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be n and Mental H Emerson Barlow Ethel McCardell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Knisley (daughter) 3 Obrecht Rd., Sykesville, Md 21784 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite eny injury or ot once. 1 XBurial 2 Cremation 3 Removal from State Sykesville, Md Lake View Memorial 6 - 1 - 05*4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Ruph disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed physician and s the buriat-trans Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 3 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 2 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA After this of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 THomicide hin 24 hours a 29a. Certifier 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai npletely (Check only one) the within 2 To the 29b. Signature and title of certifier DOOL055 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 122 Slade Avenue Suite 101 Baltimore MD

State Registrar

Rosert Gordon 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			1 - For State Registrar		Maryland		artment rtificate			d Mental Hy	/giene Reg. No.	101.50
	Physic	ian	1. Decedent's Name <i>(First, Middle, La</i> Victoria	st) Lynn		Gray				2. Date of De May 2	eath 4. 2005 Year	3. Time of Death 3:50AM _M
	/Medi Examii		4a. Facility Name (If not institution, given Southern Marylan	e street and num			4b. City, 1		Location of D		4c. County of Deat Prince Ge	n
1	Funeral Director		5. Social Security Number 212-80-3710 Usual Residence of Decedent	Sex I□M 21/2]F	42 42	st birthday) Yrs.	If Under Months	1 Year Days	If Under 24 H Hours M	Min. (Month. D.	nth (26, 1963 Mar) 9. Birth (26, 1963 Mar)	nplace (State or Foreign unity) 'yland
	Maryland -f show	tor	10a. State 10b. County Maryland Prince G	eorge's	10c. City,	Town or Lo	cation Suitla	and				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the 3a or 28e	I Director	10e. Street and Number 3229 Swan Road #				10f. Zip		;		10g. Citizen of What Co	untry?
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "naturel", or items 23a or 28e-f show or other treumetic event, the Modical Examinational benotified at	by Funeral	11. Marital Status 1 Never Married 22 Married 3 Widowed 4 Divorced		lent Ever in U.S ces? No les:		Was Decede 1 Yes, speci 1 □ Yes 2		panic Origin? , Mexican, Pu Specify:	(Specify Yes or No Jerto Rican, etc.)	Specify: Atr	
Maryland 21215-0036	od within 72 ho giene. er than "netur , the Medical	Completed by	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12th	ducation ade completed) College (1-	4or 5+)	(Give life. L	dent's Usual kind of work DO NOT use Clerk	k done du e retired)	ion uring most of	working	16b. Kind of Business/	ndustry
/land	3.2 should be filed within h and Mental Hygiene. 7 is marked other than "treumetic event, the Me.	To Be (17. Father's Name (First, Middle, Last Clifford Tay							Name <i>(First, Middle</i> a Helen Y	o, Maiden Sumame) OUNG	
	1 and 2 sho Health and t tem 27 is me		19a. Informant's Name/Relationship (Anthony Gray (Hus								per, City or Town, State, 2 , Maryland 2	
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 eny injury or other tr once.		20a. Method of Disposition 1 DBurial 2 Cremation 3 C 4 Donation 5 Other (Special		tate Cer	nce of Dispo metery, cren rrect:	natory or oth ion Ce	her place, emete	ery 20	ay ^D 28,	20c. Location - City or Clinton, N	Maryland
Balt	permit. Departr Importe eny inji		21. Signature of Funeral Sprice Lice	fail	10019						ral Home, Ir Road Clinto	
8760,	cate be executed // Medical // Medical and purial-fransit the burial-fransit	dical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Classes or just that initiated events resulting in death) Last	a. Due to (o	used the death. ch line.	ence of): ence of):	er the mode	of dying,	such as card	diac or respiratory a	irrest,	Approximate Interval Between Onset and Death
O. Box 6	ath certifi attending for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 Fetal d nt at time of dea	death 3□	Ectopic pre				23d. Date of deliver Month	rery Day Year
S, D	w requires that the de been signed by the s should be detached t	by	Part II. Other significant conditions of	ontributing to dea	th but not result	ting in the ur	iderlying cai	use given	in Part I.		obacco use contribute to	
Vital Record		Completed								24a. Was autoj perio 1 🗆 Yes		opsy findings available ompletion of cause of
Vit	Physicien: T this certificat ral director, pa	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Datient 2 ☐ El	R/Outpatient				Death (Check only on Home 5 Resident	one) dence 6 □Other (Spec	6.1
	ding h. After fune	ertification; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of (Month,		8b. Time of Injury		c. Injury a Work?	at		how injury occurred	97
Division	tel or Attend s after death el Director: , ed in by the f	Certiflo	3 Suicide 6 Could not b 4 Homicide determined	28e. Place o	f Injury - At hom g, etc. <i>(Specify)</i>	e, farm, stre	eet, factory,	office		28f. Location (City or Tox	Street and Number or Rui wn, State)	al Route Number,
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edical	(Check only 2) Medical Evan	MIDAP On the hac	ic of avaminatio	and/or inv	actionation i	a mu anir	sion donah	and a state of the state of	cause(s) and manner as date and place, and due	- 46 / - 1
)	To the i	M	29b. Signature and title of certifier	~	_ ^	-0.	29c.	License r	3 4 4	6	29d. Date signed (Month,	Day, Year)
	6		30. Name and address of person who	completed cause	of death (Item 2	23a) (Type, F	Print)	Gen	2 : A	n suito	- 6, silva	50902
	Sta Registr		29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who ROLANGE FA 31. Date filed (Month, Day, Year) JUN 0 2 20	05	distrar's Signatur	re So	uf	/	ye m		71	/ //٦٥

			State of Maryland / Department	artment of Health and M Tificate of Death		ene g. No. 0 0 5	18454
	Dhuaisi		Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	Physici /Medic		Josef Gorski		May 24	, 2005	8:07AM M
	Examir	er	4a. Facility Name (If not institution, give street and number) Bradford Oaks	4b. City, Town, or Location of Death Clinton		4c. County of Death Prince Geo	raala
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthola	ice (State or Foreign
	Director		579-52-5213 1\(\tilde{\Pi}\) M 2□F 82 Yrs.	Months Days Hours Min.	Feb. 26,	Year) Couintr 1923 Polan	d d
	Mo M		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation		10	d. Inside City Limits
	a-fsh	tor	Maryland Prince George's	Clinton			1 □Yes 2¶No
	or 28	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Countr	y?
	e 23s		6815 Louise Lane 11 Marital Status 12. Was Decedent Ever in U.S. 13. V	20735	-"	U.S.A.	
Maryland 21215-0036	be filed within 72 hours efter death with the Marylend that Hygiene. ad other than "naturel", or Itame 23a or 28a-f show event, the Medical Examinat must be notified at	by Funerai	Y Armed Forces? I 1 □ Never Married 2 ↑ Married 1 □ Yes 2 √√√√ No	Was Decedent of Hispanic Origin? (Spe if Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2 1 No Specify:	city Yes or No- Rican, etc.)	14. Race - America Black, White, et Specify. White	tc.
5-0	"natu	ietec	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working	ng 16	6b. Kind of Business/Indu	stry
12	withir iene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Pain	DO NOT use retired) ter		Contractor	
פ	al Hyg other	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name			- 11
ylar	2 should be n and Mental r Is marked o reumatic eve	ToE	Wojczech Wolinski Wojciech Gors				
, Mar	bug Emp		Irene Gorski (Wife) 6815	ng Address (Street and Number or Aural Louise Lane Clint			Code)
Baltimore,	permit. Pages 1 and 2 Department of Health s Importent: If Item 27 Is any injury or other tre		TEXOGRAPH 2 CONTINUES OF THE PROPERTY OF THE P	000	21,	Oc. Location - City or Tow	n, State
Ħ	artmen artmen ortent: injury			tion Cemetery 200 2. Name and Address of Facility Lee		Clinton, M	aryland
Ba	Depa Impo any i		. 11 11 1 1 1 2 11	633 Old Alexandria			, MD20735
	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury)	ar the mode of dying, such as cardiac of			Approximate niterval Between Dissertion and Death
× (98280)	rtificate be executed ng physician and s as the burial-transit	Medicai Examiner	Cause (Disease or Injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d.				
.O. Box	that the death certificed by the attending to detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of delivery Month D	y Year
ords, P	The law requires that the ate has been signed by th bage 2 should be detache	ted by P	Part II. Other significant conditions contributing to death but not resulting in the un PARICINSON S (SEACE	nderlying cause given in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to the	cause of death?
Vital Records,	The law rate has be page 2 shu	Completed by			24a. Was an autopsy performe	prior to comp	y findings available pletion of cause of
/ita	Physician: The this certificate har director, page	Be	25. Was case referred to medical examiner?	26. Place of Death		1	
of	Physi this or ral dire	. To	1 ☐ Yes No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien 27. Manner of Death 28a. Date of Injury 28b. Time of	-	ne 5 🗆 Residence 8d. Describe how	ce 6 Other (Specify)	
O	Attanding in death. ector: After by the funer	ition	Natural 5 Pending (Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No	od. Describe flow	inquiy occurred	
Division	I or Attandi efter death Director: A d in by the fu	ertification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specity)	eet, factory, office	8f. Location (Stre City or Town,	et and Number or Rural F State)	Route Number,
	To the Hospital or Attanding Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death and manner stated.	occurred at the time, date and place, and restigation, in my opinion, death occurre	nd due to the cau d at the time, date	se(s) and manner as stat e and place, and due to the	ed. ne cause(s)
)	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month, Da	700 (
	j		30. Name and address of person who completed cause of death (Item 23a) (Type,		14(77 -01	2003
	6		Philip Wisotsky MD 12070 Old Line 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Centre # 207 Wald	dorf, Ma	ryland 20602	2
	Sta Registr		JUN 0 2 2005	6			
DH	MH 17 Rev 1/20	001		park			
			ORIGINA	AL.			

PAYS COMPANIES AND PROVIDED BY A FORM YEAR OF THE PROVIDED BY A SECURITY OF DEED BY A SE			1. Decedent's Name (First, A	Aiddle, La	st)					Death		2. Date of De			3. Time	of De
## AFEINITY Name of not extending, ope crase and number 1.00 per control possible 46 CUT; Town or Location Death 48 ARNIN ARTINDEL ANNE ARIUNDEL ANNE ARIUNDEL ANNE ARIUNDEL 1.00 per control possible 40 CUT; Town or Location 1.00 per control possible 40 CUT; Town or Location 1.00 per control possible 40 CUT; Town or Location 1.00 per control possible 40 CUT; Town or Location 1.00 per control possible 40 CUT; Town or Location 1.00 per control possible 40 CUT; Town or Location 1.00 per control possible 1.00 per control			Marion	(ο.			Graha	am			Month May	27	2ŎO5	4:12	2 P
Social Security Number Control Security Number Control Security			4a. Facility Name (If not instit	tution, giv	re street and nu	ımber)		4b. City,	Town, or	Location	of Death		4c. C	ounty of Death	.1	
Decided Reactions and Discussions Tool. Incide City Town or Location Tool. Incide City Town or Location Tool. Incide City Town or Location Tool. Incide City Town or Location Tool. Incide City Town or Location Tool. Incide City Town or Location Tool. Incide City Town or Location Tool. Incide City Town or Location Tool. Incide City Town or Location Tool. Incide City Town or Location Tool. Incide City Town or Location Tool. Incide City Town or Location Tool. Incide City Town or Location Tool. Incide City Town or Location			Morningside	Hous	se									IE ARUNI	DEL	
10.5 State 10.5 Country 10.5 City Fown of Location 10.5 City Fown			224-16-4042	1	Sex 12XM 2□F							8. Date of Bir (Month, Da 12/25/	1912	9. Birth Cou VIRG	place (State ntry) [NIA	or F
15. Decedent s Education 15. Decedent Substantion 15. Kind of Basinsssindustry 15. Kind of Basinssindustry 15. Kind of Basinssindustry 15. Kind of Basinssindustry 15. Kind	show	7	10a. State 10b. Co	unty	DIINDET											-
15. Decedents Education 16. Decedents Usual Occupation 16. Decedents Usual Occupation 16. Decedents Usual Occupation 17. Occupation 18. Decedents Usual Occupation 18. Months of Name (First, Middle, Last) 18. Months of Name (First, Middle, Last) 18. Months of Name (First, Middle, Maisland Name) 18. Months of N	28a-f	ecto		NE AI		r	TANOVER		0.1				10 000			
16. Decedent Support of the property of the	a or	급		CODAT	DI DOAD										ntry?	
15. Decededn't Expression 15. Decededn't Expression 16. Decededn't Usual Occupation 16. Decededn't Usual Occupation 16. Mother's Name (Prist, Middle, Last) 17. Faither's Name (Prist, Middle, Last) 17. Faither's Name (Prist, Middle, Last) 18. Mother's Name (Prist, Middle, MakSon Sumanne) 18. Mother's Name (Prist	ns 23	eral		EGNAI	12. Was Dec	edent Ever in	U.S. 13			spanic Ori	igin? (Sp	ecify Yes or No			can Indian.	
15. Decedents Education 16. Decedents Usual Occupation (Genetly on hybrids practs completed) 17. Father's Name (First, Middle, Lats) 18. Mother's Name (First, Middle, Lats) 18. Mother's Name (First, Middle, Lats) 19. Mailing Accress (Street and Number or Rural Route Number, City or Town, State, Zip Cools) 19. Mother's Name (First, Middle, Lats) 19. Mailing Accress (Street and Number or Rural Route Number, City or Town, State, Zip Cools) 19. Mailing Accress (Street and Number or Rural Route Number, City or Town, State, Zip Cools) 19. Mailing Accress (Street and Number or Rural Route Number, City or Town, State, Zip Cools) 19. Mailing Accress (Street and Number or Rural Route Number, City or Town, State, Zip Cools) 19. Mailing Accress (Street and Number or Rural Route Number, City or Town, State, Zip Cools) 19. Mailing Accress (Street and Number or Rural Route Number, City or Town, State, Zip Cools) 19. Mailing Accress (Street and Number or Rural Route Number, City or Town, State, Zip Cools) 19. Mailing Accress (Street and Number or Rural Route Number, City or Town, State, Zip Cools) 19. Mailing Accress (Street and Number or Rural Route Number, City or Town, State, Zip Cools) 19. Mailing Accress (Street and Number or Rural Route Number, City or Town, State, Zip Cools) 19. Mailing Accress (Street and Number or Rural Route Number, City or Town, State, Zip Cools) 19. Mailing Accress (Street and Number or Rural Route Number, City or Town, State, Zip Cools) 19. Mailing Accress (Street and Number or Rural Route Number, City or Town, State, Zip Cools) 19. My Etter Rural Street Street, City or Town, State, Zip Cools) 19. My Etter Rural Street, City or Town, State, Zip Cools) 19. My Etter Rural Street, City or Town, State, Zip Cools) 19. My Etter Rural Street, City or Town, State, Zip Cools) 19. My Etter Rural Street, City or Town, State, Zip Cools, Street, City or Town, State, Zip Cools, Street, City or Town, State, Zip Cools, Street, City or Town, State, Zip Cools, Street, City or Town, State, Z	if, or Itan	by Fun	1 ☐ Never Married 2 점		Amned F	orces? 2 ☐ No						Rican, etc.)		Black, White,	etc.	
Semantically its conditions College (1-4or 5+) ASSISTANT SUPERVISOR STATE OF MARYLAND		ted			ducation		16a. Dec	edent's Usua	al Occupa	ation		in a	16b. Kind	of Business/Ir	dustry	
The Father's Name (Pists, Middle, Madden Suramen) RATRUM JOHNSON GRAHM RATRUM JOHNSON GRAHM 196. Mailing Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code) PMA CRAHAM — WIFE 196. Mailing Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code) PMA CRAHAM — WIFE 200. Location - City or Town, State, Zip Code) All Contents on John State of Code of Special Stat	an "n	ple.					life.	e kind of wo DO NOT us	se retired	iuring mos)	t of work	ing				
The Father's Name (Pist, Middle, Maddler Surame) (Father Stame (Pist, Middle, Maddler, City or Town, State, Zip Code) (Father Stame (Pist, Middle, Maddler, City or Town, State, Zip Code) (Father Stame (Pist, Middle, Maddler, City or Town, State, Zip Code) (Father Stame (Pist, Middle, Maddler, City or Town, State, Zip Code) (Father Stame (Pist, Middler, City or Town, State, Zip Code) (Father Stame (Pist, Middler, City or Town, State, Zip Code) (Father Stame (Pist, Middler, City or Town, State, Zip Code) (Father Stame (Pist, Middler, City or Town, State, Zip Code) (Father Stame (Pist, Middler, City or Town, State, Zip Code) (Father Stame (Pist, Middler, City or Town, State, Zip Code) (Father Stame (Pist, Middler, City or Town, State, Zip Code) (Father Stame (Pist, Middler, City or Town, State, Zip Code) (Father Stame (Pist, Middler, City or Town, State, Zip Code) (Father Stame (Pist, Middler, City or Town, State, Zip Code) (Father Stame (Pist, Middler, City or Town, State, Zip Code) (Father Stame (Pist, Middler, City or Town, State, Zip Code) (Father Stame (Pist, Middler, City or Town, State, Z		Con	12				ASSI	STANT	SUPI						RYLAN	ID_
ARTHUR JOHNSON GRAHAM Second Continue	d oth evant	Be											Maiden S	u <i>mame)</i>		
20a. Meniod of Disposition 1.5 Signal 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Alphanol 20b) 1.5 Signal 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Alphanol 20b) 1.5 Signal 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Alphanol 20b) 1.5 Signal 3 Cremation 3 Removal from State 22b. Signal 4 Command of Alphanol 20b) 22b. Signal 4 Command of Barbaria (Name) 22b. Signal 4 Command of Barbaria (Name) 22b. Signal 4 Command of Barbaria (Name) 22c. Name and Address of Facility SINGLETON FUNERAL HOME P.A. 1 SECOND AVE. S.W., GLEN BURNTE, MD 21061 23c. Place of Original Causer (First Individual Frail States) 25c. Legislating in death) 25c. Legislating in death) 25c. Legislating in death) 25c. Legislating in death) 25c. Legislating in death) 25c. Legislating in death) 25c. Legislating in death) 25c. Legislating in death) 25c. Legislating in death) 25c. Legislating in death) 25c. Legislating in death) 25c. Legislating in death) 25c. Legislating in death) 25c. Legislating in death) 25c. Legislating in death) 25c. Legislating in death) 25c. Was case referrigation medical seaminary of the Legislating in death of the cause of death of the Legislating in death) 25c. Was case referrigation medical seaminary of the Legislating in death of the Cause of the Legislating in death of the Cause of the Legislating in death of the Causer of the Legislating in death of the Causer of the Legislating in death of the Causer of the Legislating in death of the Causer of the Legislating in death) 25c. Was case referrigation medical seaminary of the Legislating in the underlying cause given in Part I. 25c. Place of Death (Name) 25c. Was case referrigation medical seaminary of the Legislating in the Underlying Causer of the Legislating in the Underlying Causer of the Legislating in the Underlying Causer of the Legislating in the Underlying Causer of the Legislating in the Underlying Causer of the Legislating in the Underlying Causer of the Legislating		ပ္														
200. Mysnod of Disposition 1-Silvagia 2 Ceremation 3 Removal from State 200. Place of Disposition (Name of All Populations 2 CROWNSVILLE, MD 21. Signature of Disposition (Name of All Populations 2 CROWNSVILLE, MD 22. Name and Address of Facility S INGLETON FUNERAL HOME P.A. 2 Second All Populations 2 Seco	raum raum				•			_					•			
A Departure So Depart Secure So Depart Secure So Departure So Depar	her t			- MTI	TE .	20h	***									
21. Signals of Europe Month (2) and an accordance of Scilly Singleton Funeral Home P.A. I SECOND AVE. S.W., GLEN BURNIE, MD 21061 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, improved and be specifically appeared to the complete of the			1 ♣ Byrial 2 ☐ Cremat			State								,		
Sicilan collision Sici	njury					MI			-							
spoke, or heart failure. List only one cause on each line. Immosister Cause (Final diagnose or condition diagnose or condition) Sequentially list conditions, any, leading to immediate cause. Effect underlying that imitiated events any leading to immediate cause. Effect underlying that imitiated events are caused to the cause of the cause o	2 - 3		21 Signature of Fusiet Ser	vice Line	nsee			Name an	nd Addres	s of Facili	by SI	NGLETON	FUNE	RAL HOM	E P.A	
F FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Yes 2 No 9 Unknown 9			23a. Part1. Enter the diseas spock, or heart failure. Immediate Cause (Final	e, or com List only	pplications that one cause on	caused the de each line.	ath. Do not e	SECON	ND AN	g, such as	.W.,	GLEN B	URNIE	, MD 21	Approxim Interval B	ate etwe
Part II. Other significant conditions contribute to the cause of deal of the cause of deal	sician edical miner		26a. Payl 1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	List only	pplications that one cause on Due to Due to c.	caused the de each line. 1 O C A (or as a conse	equence of):	SECON	ND AV	g, such as	.W.,	GLEN B	URNIE	, MD 21	Approxim Interval B Onset and	ate etwe d De
25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Mannar of Death 1 Matural 5 Pending investigation 28a. Date of Injury 28b. Time of Injury 2 No 27. Mannar of Death 28. Place of Death (Check only one) 28. Place	attending physician and important control of the purial-transit and in the purial-transit and in the purial transit and in	cal	29a. Part. Enter the diseas shock, or heart failure. Immediate Cause (Final dispass or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 Yes 2 No	{	pplications that one cause on Due to b. Due to c. Due to d. 23c. If yes, ou 1 Live 4 Preg	caused the deeach line. (or as a consection of pregion of the property of the	equence of): equence of): equence of):	SECON	ND AT de of dying	g, such as	.W.,	GLEN B	URNIE	d. Date of deliv	Approxim Interval B Onset and I 1-	ate etwe d De
25. Was case referred to medical examiner? 1	gned by the attending physician and indicated for use as the burial-transit be detached for use as the burial-transit	by Physiclan/Medical	29a. Part. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1	List only	pplications that one cause on one cause on one cause on one cause on one cause on one cause on one cause on one cause on one cause on one cause on one cause on one cause on one cause on one cause	caused the deeach line. 1 O C A (or as a consection of pregion of	equence of): equence of): equence of): equence of): financy stal death financy	SECON	ND AT de of dying	g, such as	.W., cardiac	GLEN Bor respiratory a	URNIE rrest,	d. Date of delive Month	Approxim Interval B Onset and I 1-	Yea
The part of the	has been signed by the attending physician and including properties as the burial-transit including the detached for use as the burial-transit including the properties of the	by Physiclan/Medical	29a. Part. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1	List only	pplications that one cause on one cause on one cause on one cause on one cause on one cause on one cause on one cause on one cause on one cause on one cause on one cause on one cause on one cause	caused the deeach line. 1 O C A (or as a consection of pregion of	equence of): equence of): equence of): equence of): financy stal death financy	SECON	ND AV	g, such as	.W., cardiac	GLEN E or respiratory a control of the control of t	URNIE rrest, 23 23 cobacco use res 2 an ssy	d. Date of delive Month a contribute to technique of the contribute to technique of the contribute to technique of the contribute of the	Approxim Interval B Onset and Interval B Onset and I 1 - 2 O O O O O O O O O O O O O O O O O O	Yea
27. Manne of Death 1	has been signed by the attending physician and including properties as the burial-transit including the detached for use as the burial-transit including the properties of the	Completed by Physiclan/Medical	29a. Part. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decadent pregnan in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant cor	t additions of	pplications that one cause on one cause on one cause on one cause on one cause on one cause on one cause on one cause on one cause on one cause on one cause on one cause on one cause on one cause	caused the deeach line. 1 O C A (or as a consection of pregion of	equence of): equence of): equence of): equence of): financy stal death financy	SECON	ND AV	g, such as	cardiac	23e. Did to 24a. Was auto perfect of 1 Yes	23 cobacco use yes 2 an an siny med? 2 Sto	d. Date of delive Month contribute to to the contribute to the co	Approxim Interval B Onset and I 1-2 O O O O O O O O O O O O O O O O O O O	Yea i dea
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)	certificate has been signed by the attending physician and in policies of the burial-transit in policies of	Be Completed by Physiclan/Medical	29a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant cor	t additions of	pplications that one cause one cause on one cause on one cause on one cause on one	caused the deeach line. (or as a consection of pregion of pregion and at time of nown death but not research line.	equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of):	SECON	vecify)	g, such as	cardiac cardia	23e. Did to 24a. Was auto perfect of 1 Yes	URNIE rrest, 23 cobacco use res 2 an an an an an an an an an an an an an a	d. Date of delive Month contribute to to the contribute to the contribute to the contribute autoprior to content? 1 Yes	Approxim Interval B Onset and I 1 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Yea i dea
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	After this certificate has been signed by the attending physician and in polyticate has been signed by the attending physician and in polyticate in the polyticate in the polyticate in	To Be Completed by Physiclan/Medical	26a. Part1. Enter the diseas stock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant cor 25. Was case referred to me examiner? 1 Yes 2 No 27. Manna of Death 1 Natural 5 Pe	t dical	pplications that one cause one cause on one cause on one cause on one cause on one	caused the deeach line. (or as a consection of pregion	equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of):	SECON Inter the mod SCIECtopic price of control of co	regnancy pecify) DA Other	g, such as	cardiac cardia	23e. Did 1 24a. Was auto perfo	23 cobacco uses yes 2 an an an an an an an an an an an an an a	d. Date of delive Month contribute to to the prior to condeath? 1 Yes	Approxim Interval B Onset and I 1 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Yea
John Stram, M. n 8)2)838 JUNITA 1, 2005	ctor: After this certificate has been signed by the attending physician and in property of the funeral director, page 2 should be detached for use as the burial-transit in property in the funeral director.	To Be Completed by Physiclan/Medical	29a. Part. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1	t dical	Due to a. Due to b. Due to c. Due to d. 23c. If yes, ou 1 Live 4 Preg 9 Unkr contributing to co Hospital: 28a. Date (Mor	caused the deeach line. (or as a consection of pregion	equence of): equen	SECON The mod B Ectopic pr Other (sp underlying co of 2 M	regnancy pecify) DA Other	g, such as	cardiac cardia	23e. Did to the control of the contr	23 cobacco uses (res 2 an an assymmed? 2 and an an an an an an an an an an an an an	d. Date of deliving Month d. Date of deliving Month e contribute to to the contribute to the contrib	Approxim Interval B Onset and I 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Year i dea
1 John Stram, M. n 8)2)838 JUNITA 1, 2005	ctor: After this certificate has been signed by the attending physician and in property of the funeral director, page 2 should be detached for use as the burial-transit in property in the funeral director.	Certification: To Be Completed by Physician/Medical	26a. Part1. Enter the diseas stock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1	dical dical	pplications that one cause one cause on one cause on one cause on one cause on one	caused the deeach line. I O C A (or as a consection of pregion of the consection of pregion of the consection of the c	equence of): eq	SECON The the mod SECON SEC	regnancy pecify) DA Other Sec. Injury Work 1 1 v.	g, such as 2 26. Place art 4 2 4 3 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	cardiac cardia	23e. Did to the control of the contr	URNIE rrest, 23 23 23 25 25 26 27 27 28 28 29 29 20 20 20 20 20 20 20 20	d. Date of deliv Month contribute to t No 3 Prot 24b. Were autor prior to condeath? 1 Yes Other (Special Conditions) Other (Special Conditions) Other (Special Conditions)	Approxim Interval B Onset and I 1 2 0 0 1 1 2 0 0 1 1 2 0 1 1 2 0 1 1 2 1 1 1 1	Yea i dear
	ctor: After this certificate has been signed by the attending physician and in property of the funeral director, page 2 should be detached for use as the burial-transit in property in the funeral director.	edical Certification: To Be Completed by Physician/Medical	26a. Part1. Enter the diseas stock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1	t dical ending vestigatio buld not betermined	pplications that one cause one cause on one cause on one cause on one cause on one	caused the deeach line. I O C A (or as a consection of pregion of the consection of pregion of the consection of the c	equence of): eq	SECON Inter the mod B Conter	regnancy pecify) DA Other Page: Injury Work Type of dying Type	26. Place or at 19	cardiac cardia	23e. Did to the control of the contr	URNIE rrest, 23 23 23 24 25 25 26 27 27 28 29 29 29 20 20 20 20 20 20 20	d. Date of deliv Month e contribute to t No 3 Prot 24b. Were autorior to codeath? 1 Yes Other (Special Concourred)	Approxim Interval B Onset and I 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Yea f dear
	ctor: After this certificate has been signed by the attending physician and in property of the funeral director, page 2 should be detached for use as the burial-transit in property in the funeral director.	edical Certification: To Be Completed by Physician/Medical	26a. Part1. Enter the diseas stock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1	t dical ending vestigatio buld not betermined	pplications that one cause one cause on one cause on one cause on one cause on one	caused the deeach line. I O C A (or as a consection of pregion of the consection of pregion of the consection of the c	equence of): eq	SECON Inter the mod B Ectopic price of Other (spinor) and of 2 M street, factory ath occurred investigation	regnancy pecify) DA Other Rescurse give ause give at the time, in my op c. License.	26. Place or at 19	cardiac of Death Irrsing Ho	GLEN Bor respiratory and respiratory and the tother red at the time,	URNIE rrest, 23 23 23 24 25 25 26 27 27 28 29 29 29 29 29 29 29 29 29	d. Date of delive Month a contribute to to the prior to condeath? 1 Yes Other (Special Conditions) Other (Special Conditions) Individual Conditions of the prior to condeath? Individual Conditions of the prior to condeath? Individual Conditions of the prior to condeath? Individual Conditions of the prior to condeath? Individual Conditions of the prior to conditi	Approxim Interval B Onset and I 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Yea f dear

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JACK GREEN MAY 28 2005 5:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JEWISH CONVALESCENT CENTER BALTIMORE BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAY 17, 1910 Birthplace (State or Foreign Country) **Funeral** Days Hours 124-10-9962 95 ĆANADA Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 7920 SCOTTS LEVEL ROAD or Itams 23a 21208 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Xi Yes 2 \sum No ARMY If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🂢 No þ Specify: WHITE If Yes, Givo Year or Dates: 3 Widowed 4 Divorced WWII "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygient Important: If Itam 27 is marked other the eny injury or other traumating. SALES RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (UNKNOWN) GREEN (UNKNOWN) ပ္ (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town; State, Zip Code) BRENDA FISCHER / NIECE 1753 CROWNSVILLE ROAD - ANNAPOLIS, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State VETERANS CEMETERY 06/06/2005 | OWINGS MILLS, MD ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PI or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. <u> 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</u> Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner and I-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a I for use as the burial Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No detached the 9 Unknown 9 Unknown ģ signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes been 24b. Were autopsy findings available prior to completion of cause of death?

1 2 Yes 2 No 24a. Was an page 2 autopsy performed? certificate 2 7 1 Yes Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 ursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 No 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral in the fun 27. Manny of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Medical Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide artifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29b. Signature and title of certifier 29c. License number who completed cause of death (Item 23a) (Type, Print) 30. Name and a ress of person 31. Date filed (Month, 32. Registrar's Signature State 2005 0 Registrar

			State of Maryland / Department of Health and Mental Hygiene	
			1 = State Contificate of Dooth	
			Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death	7
	Physici		T Day Year	PM "
	/Medio Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
1				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Fore Months) Days Hours Min. (Month, Day, Year) (Country)	ign
ı.	Director		239-68-3599 Will 20 Oct. 12,1942 North Carpli	na
	pur *			i a a
	faryla sho	៦	M_{\star} () Λ/Λ	
	28a-	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	_
	Mith Ba or		374 F 22nd St 2120	
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
9	after or Ital		1 □ Never Married 2 □ Married 1 □ Yes 2 KT No	
21215-0036	hours after death with the Maryland tural', or Itams 23a or 28a-f show al Examiner must be notitied at	d by	3 □ Widowed 4 M Divorced If Yes, Give Year or Dates: 1 □ Yes 2 No Specify: Specif	
5-0	72 h	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working) 16b. Kind of Business/Industry	
2	within ene. than "	mpi	Elementary/Secondary (0-12) College (1-4or 5+) IIIB. DO NOT use retired)	
	filed v Hygie ithar t		12	
and	t be f ntal h ad of	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
Maryland	should nd Me mark mark	은	19a. Informant's Name/Relationship (Type, Print) (b(other) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Ma	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hyglene. It man 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic avant, it a Medical Evaniner must be notified at		Mc Tofficer (Scale Continue) 32/1/E 22-1 St Bull Million City of Your, State, 210 Code)	
ē,	s 1 ar f Hea itam other		20a. Method of Disposition Date 20c. Location - City or Town, State	_
E O	e = 10 de		1 Burial 2 Cremation 3 Manmoval from State Commetery, crematory or other place) 14 Donation 5 Other (Specify) Vorth Side Cemetery 6/2/2005 Furtheride North Card	
Baltimore	- E 2 -		21. Signature of Funeral Service Licenses? 22. Name and Address of Facility	1116
m	permi Depa Impo any is	10	Joseph L. Russ Funeral Home P.A.	
			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shipter, or hearthfailure. List only one cause on each line. Immediate Cause (Final	
	Physician		Immediate Cause (Final disease or condition PROBABCE MY O CARDIAL IN FACTORS and Death	
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	
Н		-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):	1
Ī	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events caused (Disease or injury that initiated (Disease or injury that initiated (Disease or injury that initiated (Disease or injury that initiated (Disease or injury that initiated (Disease or injury that initiated (Disease or injury that initiated (Disease or injury that initiated (Disease or injury that initiated (Disease or injury that initiated (Disease or injury that initiated (Disease or injury that initiated (Disease or injury that initiated (Disease or injury that initiated (Disease or injury that initiated (Disease or injury that injury that injury that injury that injury that injury that injury that injury that injury	R
, O	be executed iician and burial-transit		resulting in death) Last Due to (or as a consequence of):	
3760	e ys	icai	d	
K 68	w requires that the death certifica been signed by the attending ph should be detached for use as th	by Physician/Med	IF FEMALE:	
Вох	ath cattend	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Prognant at time of death 5 Characteristics (April 12 months)	
0	the de	ysic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 9 Unknown 9 1 1 1 1 1 1 1 1 1	
s, P.	that hed by deta	УРЬ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	
rds	The law requires that the site has been signed by the bage 2 should be detache	ed b	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknow	'n
Record	aw re	Completed	24a. Was an 24b. Were autopsy findings availab	le
Ä	The late happened	mo	autopsy prior to completion of cause of performed? death? 1 □ Yes 2 ☑ No 1 □ Yes 2 □ No	
Vital	sian: artifica ctor, i	Bec	25. Was case referred to medical 26. Place of Death (Check only one)	
	hysic his ce Il dire	ို	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
n c	ing P	ion:	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28c. Injury at Work?	
isio	ttand death stor:	icat	2 Accident investigation 3 Suicide 6 Could not be	
Division of	after Dirac	Certification:	Suicide determined determined determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	spita nours naral		29a. Certifier (Cherk and (Cherk	_
	To the Hospital or Attanding Physician: The law within 24 hours after death. To tha Funaral Diractor: After this certificate has completely filled in by the funeral director, page 2.	edical	(Check only one) Check only one Check one Check only one Check one Check one Check one Check	
	with to t	Σ	29b. Signature and title of certifer 29d. Date signed (Month, Day, Year)	
•			N40 J37 6/1/05	
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 2 8 9 1 2 2 2 9 1 2 2 2 2 2 2 2 2 2 2 2 2 2	
	Sta		31. Date filed (Month, Day, Year) 32 legistrar's Signature 32 legistrar's Signature	
	Registr	ar	JUNIO & 2003 Blown St. Species	

Division of Vital Records, P.O. Box 68760.

			State of Maryland / Department of Certificate	of Dooth	
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Julius C. Hall	2. Date of Death Month Day L 2. Date of Death L A A L A	Year 3. Time of Death. p
	Examir Funeral Director			4b. City, Town, or Location of Death About 1	9. Britiplace (State or Foreign
	hours after death with the Maryland turel', or thems 23a or 28a-f show al Examiner must be notified at	Funeral Director	10a. State 10b. County 10c. City, Town or Location 10c. Street and Number 10b. Street and Number 10c. Street and Number 10c. Street and Number 10c. Street and Number 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location	de 10g. Citizen of 1 10g. Citizen of 1 10g. Citizen of 1 10g. Citizen of 1 114. Rac	SA ee - American Indian,
15-0020	CI 100	Completed by Fu	1 Never Married 2 Married 1 A Yes 2 No 1 Ye	(No Specify: Specify	ck, White, etc. Black usiness/Industry
Maryland 21215-0020	be filed within tal Hygiene. d other than event, the Ma	Be	Elementary/Secondary (0-12) College (1-4or 5+) Tant C 17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Suman	ate Firm
	t and 2 shou Health and M Iem 27 Is mar other traumat	To	Mrs. Floretta Weems 70 NA	reet and Number or Rural Route Number, City or Town, Ington Ave #509 B	State, Zip Code) atto. Md. 21217 City or Town, State
Baltimore,	permit. Pages Department of Important: If it any Injury or once.		1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and A JOSEPH JOSEPH	crest 6/8/2005 Owing discuss of Eacility Likuss Funeral H	s Mills, Md.
4	Physician /Medical Examiner		23a. Part I Enter the disease, or complications that clused the death. Do not enter the mode of shock or heart fathere. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	dying, such as cardiac or respiratory arrest,	Approximate Interval Between Onset and Death
1	ted sit	Examiner	Due to (or as a consequence of):		
, 09289	icate be executed physician and s the burial-transit	dical Exar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	^.	
Ψ	ath certifica attending ph for use as th	lan/Med	d		
s, P.O. Box	v requires that the death certifichen signed by the attending should be detached for use as	by Physiclan/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause Cerebra VAS Cul An ACC 1 De		attribute to the cause of death? 3 ☐ Probably 4 ☐ Thknown
Records,	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Completed	PERCUTANEOUS GATTROS TOMY JUL	36 PLACEMEN (24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
f Vital F	yslcian: The is certificate director, pag	To Be Col	25. Was case referred to medical examiner? 1 Yes 27 No	26. Place of Death (Check only one) Other: 49-Rursing Home 5 Residence 6 Other	1 ☐ Yes 2 ☐ No
Division of Vital	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory of	njury at 28d. Describe how injury occurr Work? 1 ☐ Yes 2 ☐ No	ed
Ď	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the f	edical Certi	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in r	e time date and place and due to the cause(s) and ma	nnor as stated
	To the Vithin 2 To the I complet	Med	and mariner stated.	ense number 29d. Date signed	1 (Month, Day, Year) 2 - 2005
	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADURA L PRASHAICARM D	300 ARMIRY PLA	LE BAL MD21201
***	Stat Registra	te	31. Date filed (Month) Prin Year) 2 2005 32. Signature		1412129
DH	AH 16 Rev 6/95				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year HAIRSTON CHARLIE HUBERT 05.29. 2005 5:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST NURSING HOME 10WSON BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, 10-23 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F 228.56.0422 Yrs. Director 10a. State 10c. City, Town or Location 10b County 10d. Inside City Limits other traumatic avant, the Madical Examiner must be notified at Completed by Funeral Director 1 Yes 2 No HOWARD COLLIMBIA WD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 9612 SEA SHADON 21046 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married ō 1 ☐ Yes 2 KNo Specify: Specify: 3 Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SYSTEM ANALYST F.E.M.A. 12TH GRADE YRS Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental H is markad of JOHN HAIRSTON THELMA GRASSDY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 VIVIAN HAIRSTON 9612 SEA SHADOW, COLUMBIA MO WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 0 1 Burial 2 Cremation 3 Removal from State ō 06.07.05 injury CROWNSVILLE ' 4 ☐ Donation 5 ☐ Other (Specify) CROWNSVILLE, MD 21. Signature of Funeral Service Licensee VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATE PIKE, BALTO. MU 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Colon Cancer Metastotic Years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cades (Disease or Injury Due to (or as a consequence of): Examiner Cauce (Disease or inju-that initiated events resulting in death) Last Due to (or as a consequence of): Physician/MedIcal IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Whknown Be Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2**5**5No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence & Other (Specify) JOS PICE Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After or Attanding Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To tha Funaral D To certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Joson Kack in D May, 29, 2005 D0061199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6601 North Charles Ave Touson MD 21204 Jason Black MD 32 Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

JUN 0 2 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 3. Time of Death **Physician** EDDIE HARRIS, JR. MAY 29 2005 2:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BON SECOURS HOSPITAL CITY BALTIMORE 5. Social Security Number Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 □ F Days Hours Min Months Yrs. Director 216-40-1334 60 09/26/1944 MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. and the time 27 is marked other than "natural", or Itams 23c or 28a-f show ury or other traumatic avent, the Medical Evans naturates notified at 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Director N/A1 Yes 2 □ No BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2756 HARLEM AVENUE Funeral 21216 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specity: þ Specify: BLACK 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) BETHLEHEM STEEL Elementary/Secondary (0-12) College (1-4or 5+) CRANE OPERATOR 12TH CORPORATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EDGAR HARRIS MAUDE _GREEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACQUELINE P. GAMBLE 2756 HARLEM AVE, BALTIMORE, MD 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of P
Important: If its
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 6/6/05 CATONSVILLE, MD Funeral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Enter the disease, or complications that caused the death of or heart ailure. List only one cause on each line. Cause (Final condition Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death mmediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner As Rus To SIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical attending for usa as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, No 3 Probably 4 Unknown 1 🗀 Yes 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 2X No 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one, examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 XNatural 2 ☐ Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death Diractor: filled in by tha 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho To the Fund completely f (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 500 8K and address of person who completed cause of death (Item 23a) (Type, Print) BALKIMARE MA WETSTONE MY 7141 Secunty BIVA 31. Date filed (Month, Day, Year) State JUN 0 2 2005 Registrar

			1 - For State Registrar	State of M	aryland		artment rtificate			ınd M	-	giene Reg. No.	005	18461
	Physici /Medi		1. Decedent's Name (First, Middle, Las	st)				1-1	liax	16	2. Date of Dea Month		Year	3. Time of Death
	Examir		4a. Facility Name (If not institution, give Science Me) 5. Social Security Number 6. S	2 Lasit	erHer ge (In yrs. last	birthday)	4b. City, To	1+i Year	ocation of	56	8. Date of Birt (Month, Da 01-18-1		County of Dea	
	Director		217-24-1381 Usual Residence of Decedent 10a. State 10b. County	⊔ M 2L2F	76	Yrs.		Jays	Tiours	191111.	01-18-1	929"'		/land
	the Maryla 28a-f show	ector	MD NA			1timor	e							10d. Inside City Limits 1 Yes 2 No
	ath with	Funeral Director	10e. Street and Number 622 Carrollton Avenue		5	10	10f. Zip C	2121					en of What Co USA	
9036	ours after d rral', or Itam LExaminer I	ğ	11. Marital Status 1 🛣 Never Married 2 🗆 Married 3 🗆 Widowed 4 🗀 Divorced	12. Was Decedent Armed Forces: 1 Tes 2 In If Yes, Give Year or Dates:	?	1	was Deceder f Yes, specify		Mexican, Specify:	n? (Spe Puerto I	cify Yes or No- Rican, etc.)		4. Race - Ame Black, Whit Specify: Bla	
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Itama 23e or 28e-1 show other traumatic event, the Medical Examinar must be invilled at	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or		6a. Deced (Give life. I	dent's Usual (kind of work DO NOT use Cafeter	done dur retired)	ring most	of workir	ng		d of Business/	Industry ty Public Schoo
Maryland	uld be file Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle, Last) James Hicks					1	8. Mother Marga		(First, Middle, licks	Maiden S	Sumame)	
	and 2 sho saith and i n 27 is me		19a. Informant's Name/Relationship (7 Vera Paige/ Daughter	ype, Print)							Route Numbe			Tip Code)
altimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any Injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		ceme	of Dispo etery, cren Crema	sition (Name natory or othe atory	of er place)	06	-02-C	ate)4		ation - City or sville, I	
Ball	permit Depart Import any In		21. Signature of Funeral Service Licen	Gana		W		era1	Home	638 N			Baltimore	e, MD 21217
	Physician /Medical Examiner		23a. Part1. Enter the disease, or come shock, or heart failure. List only of limediate Cause (Final disease or condition resulting in death)	a. Core	d the death. Ene.) 11 0 V	A	er the mode o	6	such as c		r respiratory ari	est,		Approximate Interval Between Onset and Death
7	icate be executed physician and s the buriat-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence									
68760,	tificate be ng physici as the bu	l edicai		d.				-						
.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant al 9 □ Unknown	2 Fetal dea	ath 3□	Ectopic pregi Other <i>(speci</i>					23	d. Date of deli Month	very Day Year
rds, P	w requires that been signed b should be deta		Part II. Other significant conditions of	entributing to death b	ut not resulting	g in the ur	nderlying caus	se given i	in Part I.			_		the cause of death?
al Records,		Completed									24a. Was a autops perform	ned?	24b. Were aul prior to c death? 1 \(\sum \text{Yes}\)	copsy findings available completion of cause of
Division of Vital	ng Phys (fter this ineral di	Certification: To Be	25. Was case referred to medical examiner? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 ☐ Inpatie 28a. Date of Inju (Month, Da	ry 28t y Year)	Outpatient o. Time of Injury	28c.	Other: Injury at Work? 1 Pes	4 🗌 Nurs	eing Hom 2i	(Check only on the 5 The Reside 8d. Describe ho	ence 6 [occurred	
Σ	- 9		4 Homicide determined	building, et	c. (Specify)						City or Towi	n, State)		al Route Number,
	To the Hospital or within 24 hours at To the Funeral Di completely filled in	Medicai	(Check only 2 Medical Exam	rsician: To the best iner: On the basis of and manner sta	examination	and/or inv	estigation, in	my opini	on, death	occurre	d at the time d	o bos ets	lace and due	to the cause(s)
			> Machael	J Lac	ch illie	1	1) 51	146	}	2	July	signed (Month	
	3		30. Name and address of person who control was 4. 31. Date filed (Month, Day, Year)	ompleted cause of d	eath (Item 23a	A) (Type, F	Print)	Par loti	mor	p î	un 3	121	7	
	Sta Registr	-	JUN 0 2 2	005	ys signature	Y A	mode							

		1	1 - For State Registrar	State of	Maryland / Dep Ce	artment of F ertificate of	Health ar <i>Death</i>	nd Mental Hy	rgiene 005	18462
	Dhusisi		1. Decedent's Name (First, Middle, La					2. Date of De Month	eath Day Yea	3. Time of Death
	Physicia /Medic			Marily	n N. Hewlett				28, 2005	6:45 A ^M
	Examin		4a. Facility Name (If not institution, give		ber)	4b. City, Town, o		Death	4c. County of De	
			7909 Deepwell Dr		And the sem took high do.		nesda If Under 24	Hrs 0 Date of Bi	Montg	
	Funeral Director		5. Social Security Number 6. \$ 271–20–1273	M 2XTF	. Age (In yrs. last birthda) 81 Yrs.	Months Days		Min. (Month, Di	10, 1923	irthplace (State or Foreign Country) Ohio
			Usual Residence of Decedent					pecalber	10, 1725	OHIO
	nylan how		10a. State 10b. County		10c. City, Town or I					10d. Inside City Limits
	e Ma	cto	Maryland Montgo	mery	Bethesd					1 ☐ Yes 2X No
	with th	Dire	10e. Street and Number	1		10f. Zip Code 20817			10g. Citizen of What C	·
	s 23s	grai	7909 Deepwell Dr		lent Ever in U.S. 13		dispanie Orioir	n? (Specify Yes or N		nerican Indian,
36	d within 72 hours after death with the Maryland jiene. Than "netural", or Items 23a or 28e-f show the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	Armed Ford 1 Tes 2 If Yes, Give Year or Dat	es? X\ No	If Yes, specify Cub 1 ☐ Yes 2 X No	an, Mexican, I	Puerto Rican, etc.)	Black, Wi	
21215-0036	2 hou	ted	15. Decedent's E		16a. Dec	edent's Usual Occup	pation	of some officer	16b. Kind of Busines	s/Industry
215	within 7. ene. than "n	ple	(Specify only highest gri		life	e kind of work done DO NOT use retire	<i>duri</i> ng most o	or working		
2	filed wit Hygien ther th	Completed		College (1-4		Teacher	1			ation
land	ed fa	To Be	17. Father's Name (First, Middle, Last Herbert Carl Nes					s Name <i>(First, Middl</i> e Lian Swart		
Maryland	s 1 and 2 should be 1 Health and Mental Item 27 is marked oother traumatic eve		19a. Informant's Name/Relationship Richard G. Hewlet			-		or Rural Route Numb Bethesda,	er, City or Town, State Maryland	. Zip Code) 20817
dî.	ss 1 and 2 of Health item 27 i		20a. Method of Disposition		20b. Place of Disp	osition (Name of ematory or other pla	and I	Date	20c. Location - City	or Town, State
E O	Pages ent of nt: if i		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		late Mont	gomery corium, In	Mar	y 31, 2005	Bethesda,	Maryland
Baltimore,	permit. Pages 1 Department of H Important: if ite any injury or ot once.		21. Signature of Funeral Service Lich			20 Name and Addre	acc of English	Funeral Home ie. Bethesda	/Bethesda-Che Maryl <i>a</i> nd 20	vy Chase, Inc. 1814–3501
F			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that car one cause on ea	used the death. Do not e					Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)		tatic Meland	oma				2 Years
	Examiner			Due to (o	r as a consequence of):					
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (a	r as a nonsequence of)-					
	cate be executed chysician and the burial-transit	Examiner	that initiated events	C						
oʻ	e exe		resulting in death) Last	Due to (o	r as a consequence of):					
8760,	ate b	dica		d						
9	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical	IF FEMALE:	23c If was outco	ome of pregnancy				22d Data of d	olive o
Box	attene for us	cian	23b. Was decedent pregnant in the past 12 months?	1 Live bir	th 2 Fetal death 3	☐Ectopic pregnanc ☐ Other (specify) _	у		23d. Date of d Month	Day Year
o.	the y th	ysid	1 ☐ Yes 2 🕅 No 9 ☐ Unknown	9□ Unknov						
٦.		by Pł	Part II. Other significant conditions	contributing to dea	th but not resulting in the	underlying cause gr	ven in Part I.	23e. Did	tobacco use contribute	to the cause of death?
rds	v requires been sign should be		Breast Carcinom	a				1□	Yes 2X No 3□	Probably 4 Unknown
Vital Records,	The law te has b age 2 sl	ompieted						24a. Was	psy prior to ormed? death?	autopsy findings available completion of cause of
ita		BeC	25. Was case referred to medical examiner?				26. Place o	f Death (Check only		
of V	y s	70	1 ☐ Yes 2X No		patient 2 ER/Outpatie				dence 6 Other (Sp	ecify)
D C		on:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of (Month	Injury 28b. Time Day Year) Injury	Wo			how injury occurred	
Sic	teat feat tor: the	icat	2 Accident investigation 3 Suicide 6 Could not to	99 Place 6	of Injury - At home, farm, s		Yes 2□No		Street and Number or i	Bural Boute Number
Division	i or Atten after deat Director: I in by the	ertification;	4 Homicide determined	building	g, etc. (Specify)	ireet, ractory, office		City or To	wn, State)	
	To the Hospitel or At within 24 hours after or To the Funerel Direc completely filled in by	edical C	29a. Certifier 1 Certifying P. (Check only one)	nysicien: To the base and manner	pest of my knowledge, dea sis of examination and/or in er stated.	ith occurred at the ti nvestigation, in my	me, date and popinion, death	place, and due to the occurred at the time,	cause(s) and manner date and place, and di	as stated. ue to the cause(s)
	within 2 To the	Me	29b. Signature and title of certifier	col	lon mi	29c. Licens			29d. Date signed (Mo	
¥ ¥	PA		30. Name and address of perso who	completed cause	of death (Item 23a) (Type	, Print)				
١	,0,		Philip Cohen, M.D.				Vashing	ton, D.C.	20007	
	Sta	te	31. Date filed (Month, Day, Year)							
	Registr	ar	JUN 0 2 20	UD BERN	gistrar's Signature	West .				

DHMH 17 Rev 1/2001

	1 - For State of Registrar	f Maryland / Dep	artment of Health and I	Mental Hygie	No.2005 18463
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ang to 1 9 4a. Facility Name (If not institution, give street and nu.	Hawryse	4b. City, Town, or Location of Death	2. Date of Death Month May 2:	Day 2 Year 5:45 Am 4c. County of Death
Funeral Director	Harbor Hospital 5. Social Security Number 218 42 1636 6. Sex 12 M 2 F	7. Age (In yrs. last birthday) 60 Yrs.	Baltimov H Under 1 Year H Under 24 Hrs. Months Days Hours Min.		N/A 9. Birthplace (State or Foreign Country) Germany
ath with the Maryland 23a or 28e-1 show and by recilities at	Usual Residence of Decedent 10a. State 10b. County Maryland N/A 10e. Street and Number	10c. City, Town or Li		100	10d. Inside City Limits 1 No Citizen of What Country?
ter death Items 23	1417 Cherry Street 11. Marital Status 1 Never Married 2 Married 12. Was Dec Armed Fc 1 yes. Girly St. Girls St	2 X No ve	21226 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert		U.S. 14. Race - American Indian, Black, White, etc. Specify: White
1215-00 within 72 ho sne. than "natura than "natura than "malleall mapleted	(Specify only highest grade completed) Elementary/Secondary (0-12) College (16a. Dece (Give life.	dent's Usual Occupation I kind of work done during most of wor DO NOT use retired)	king	b. Kind of Business/Industry BG&E
laryland 2 2 should be filled and Mental Hygis is marked other aumatic event, II To Be Co	17. Father's Name (First, Middle, Last) Petro Hawrys 19a. Informant's Name/Relationship (Type, Print)			ne (First, Middle, Mai odora Iral Route Number, C	(not available)
Baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Men Importent: If them 27 is marke eny injury or other traumatic once.	Shirley Hawrysch / Wife 20a. Method of Disposition 1	State 20b. Place of Dispo cometery, cre- Bayview	osition (Name of matory or other place) Crematory 6/1/ 2. Name and Address of Facility	2005 Ba once Funer	, Maryland 21226 c. Location - City or Town, State altimore, Maryland ral Service, P.A. more, Maryland 21225
8760, are be executed hysician and important the burial-transit and dical Examiner	Sequentially list conditions, b. Due to cause. Enter Underlying Cause (Disease or injury that initiated events c.	caused the death. Do not en ach line. Lastatic (or as a consequence of): (or as a consequence of):	ter the mode of dying, such as cardiac Head and Neck	_	Interval Between
P.O. Box 68' that the death certificat ed by the attending phy detached for use as th	in the past 12 months?	nant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Records, e law requires the has been signed at 2 should be completed by	Part II. Other significant conditions contributing to d Hyper tension Anemia	eath but not resulting in the u	nderlying cause given in Part I.	N/	co use contribute to the cause of death? 2 \(\text{No} \) 3 \(\text{Probably} \) 4 \(\text{Unknown} \) 24b. Were autopsy findings available prior to completion of cause of death? 10 \(\text{Ves} \) 1 \(\text{Ves} \) 220 \(\text{No} \)
on of Vita	27. Manner of Death 1 Natural 2 Accident 3 Suicide 28a. Date (Mon) 28a. Date (Mon) 28a. Date (Mon) 28a. Date (Mon) 28a. Bate (Mon)	Inpatient 2 ER/Outpatient of Injury 28b. Time	Other: 4 Nursing H of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how i	and Number or Rural Route Number,
he Hosp n 24 hou he Fune pletely fil	(Check only 2 Medical Examiner: On the b	best of my knowledge, deat asis of examination and/or in ner stated.	h occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To the within to the comp	29b. Signature and title of certifier Dackash Hemilton, 30. Name and address of person who completed cause			1-B33 M	
State Registrar	30. Name and address of person who completed cause Jackson Hamilton 300	Ol South Hen legistrat's Signature	park	timore, 1	Paryland 21225

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🕦 🗋 与 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) # 2005 2. Date of Death 3. Time of Death Day 7 **Physician** ELLIS TOHNSON Month 4. 14A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE NORTHWEST HOSPITAL RANDALLSTOWN **Funeral** Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Months Days Hours Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Min. 1□M 2**M**F 212.76.4011 Director 81 Vre 11.06.1923 NC Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s not any injury or other traumatic event, the Maryland once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director BALTIMORE MD 1 ☐ Yes 2 TONO GWYNN OAK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2123 CRIMEA ROAD 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOME MAKER DOMESTIC 121H GRADE NA 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) AXUM HINTON PEARL EVANS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLE JOHNSON, SR (HUSBAND) 2123 CRIMEA RD., BALTIMORE MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 06.06.05 OWINGS MILLS, MD 21. Signature of Fungral Service Licenses 22. Name and Address of Facility
IMUGHN C. GREENE FUNERAL SERVICE Vaugh 5151 BALTO. NATE PIKE, BALTO. MO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prrysician SEPSIS SYNDROME disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** meumong 0000 Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to ras a consequence of Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronice renal disease history Completed 2⊟No 3 Probably 4 Unknown Concloso voyenlar disease 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autonsy performed? 1 ☐ Yes 2 10 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 patient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year

Kamerwany



D54188

May 2715 2005

m JET05-03573

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Charles Calvin Jenkinson State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 24^{Day} **Physician** 2005 Рм 7:03 Charles C. Jenkinson May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore University of Maryland Hospital 8. Date of Birth (Month, Day) Year) 970 Michigan If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 150 M 2□ F 35 Director 214-96-1021 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b. County r items 23a or 28e-f show ther cost be notified at 1 ☐ Yes 2 🛛 No Essex Baltimore Directo MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21221 323 Upperlanding Road death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No 1 Never Married 2X Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☑ No Specify: Specify: White If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry marked other than "natu matic event, the Madical United Crane College (1-4or 5+) Elementary/Secondary (0-12) Hygiene Crane Operator 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be h and Mental P Jeannett F. Wayland Charles F. Jenkinson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 180 Waldon Lane North East MD 21901 Department of Health a important: if item 27 is any injury or other tra Jeannette Campion /mother 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Gardens of Faith 1 Removal from State 5/28/05 Rossville MD ` 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Connelly Funeral Homeof Essex 21. Signature of Funeral Service Licenses 6 h 300 Mace Ave. Baltimore MD. 23a. Part1. Enter the disease, or complications that caused the death and not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician LIMURES Multiple disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial-1 Box 68760 physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) _ P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No 1 Yes 2 🗆 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 X Inpatient 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred operator of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: After t Natural
2 Accident
3 Suicide 5 Pending investigation molocycle involved in collision 1 ☐ Yes 2 XNo death. 2005 7.51 after death May 19 2005 7.51 PM 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) the 6 ☐ Could not be Location (Street and Number or Rural Route Number City or Town, State) Still West Re. and Mace filled in by determined 4 Homicide Esex mi) Street 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME May 25 2005 person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street 30. Name and address of Baltimore, Maryland 21201 mI Hamela E-Sovithail 31. Date filed (Month, Day, Year) JUN 0 2 2005 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene

		1	State	State of Ma	ryland / Depa <i>Cer</i>	irtment of He tificate of D			ene g. No.	
			1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death-
	Physicia			Stanley	Michael	Kordela		Month May 30		3:30 A CMO
)	/Medica Examina		4e. Fecility Name (If not institution, give si			4b. City, Town, or	Location of Death		4c. County of Dea	ith
	LXammi	'	Ivy Hall Geriatri	.c & Rehal	b Ctr.	Middle	River			ore Co.
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bii	rthplece (State or Foreign
	Director		214-20-3306	M 2□F 79	Yrs.			May 14	,1926 Mar	yland
	D .	-	Usuel Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	cation				10d. Inside City Limits
	sho	5			,		Dund	3 . 1 1e		1 ☐ Yes 2 No
	he M	Director	Maryland Balti 10e. Street and Number	more		10f. Zip Code	Dune		g. Citizen of What C	country?
	s or	흡				212	22		United St	ates
	ns 23	Funerai	7455 Durwood Road	2. Was Decedent I	Ever in U.S. 13.	Was Decedent of His f Yes, specify Cubar		ecify Yes or No-	14. Race - Am	
	r Itan	돌	1 ☐ Never Married 3€ Married	Armed Forces? XXYes 2 □ N	lo		n, mexican, Puerto Specify:	Hican, etc.)	Black, Wh	ite, etc.
3	filed within 72 hours after deeth with the Maryland Hygiene. Hysiene natural; or Items 23s or 28s-f show this then natural; or Items 20s or 28s-f show ont, the Medical Examination must be motified at	þ	3 ☐ Widowed 4 ☐ Divorced	TXYes 2 ☐ N If Yes, Give Year or Dates:	WWII	1□Yes 2∜□No	Specify.		Specify:	White
ה ה	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	tent's Usual Occupa kind of work done d	ation Juring most of work	ing	16b. Kind of Busines:	s/Industry
7	ithin ne.	후	Elementary/Secondary (0-12)	College (1-4or 5	+)	DO NOT use retired,			Coal Ind	notry.
7	ygier ygier tt.		8 Years		Cr	ane Opera	18. Mother's Nam	e (First, Middle, M		uscry
yland	tal H	Be	17. Father's Name (First, Middle, Last)					Snyder	,	
2	2 should be filed within and Mental Hygiene. Is marked other then sumatic svent, the Ms	2	Blacie Kordela 19a. Informant's Name/Relationship (Type	ne Print)	19b Mailir	ng Address (Street a			City or Town, State,	Zip Code)
g Z			Mr. Jeffery Kord						, Maryland	
o,	1 and Health em 27		20a. Method of Disposition		20b. Place of Dispo	sition (Name of		Date	20c. Location - City o	r Town, State
Baitimore,	permit. Pages 1 and Department of Health Important: If Item 2: any injury or other once.		1 XBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation # 5 ☐ Other (Specify)	emoval from State		. Cemetery		05	Baltimore	e, Maryland
	artme ortan injur		21. Signature of uneral Service License	m /)					Dundalk,	Inc
ğ	Dep Imp		Dedn.	1. Kee		922 Wise				21222
No.	3.0		23a. Part 1. Enter the disease, or complishock, or heart ailure. List only on	cations that caused	the death. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final	T /	2 cham		grdian	up ha	Alus	Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as	a consequence of):			0		
	Examiner		O THE PLAN OF THE PARTY OF THE					/		
1		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):					
	cuted nd ransi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
o	e exe ian a urial-	Ex	resulting in death) Last	Due to (or as	a consequence of):					
8760,	cate be executed physician and s the burial-transit	edical		J					1.14 1.14	
9 ×		/Me	IF FEMALE:	3c. If yes, outcome	of pregnancy				23d. Date of d	eliverv
Вох	attendation	ian	in the past 12 months?	1□Live birth 4□Pregnant at	2 Fetel death 3	□Ectopic pregnancy □ Other (specify)			Month	Day Year
P.0.	Attending Physician: The law requires that the death certif redeath. •ctor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/M	1 Yes 2 No 9 Unknown	9□ Unknown						
	that I		Part II. Other significant conditions cor	ntributing to death b	out not resulting in the u	inderlying cause give	en in Part I.	10		to the cause of death?
Sp	uires sign	d by	Demont	9,	Anemi	a .		1 □ Y	es 2 No 3 1	Probably 4 Dunknown
S	w req	lete						24a. Was a	n 24b. Were	autopsy findings available o completion of cause of
æ	The law cate has page 2	Completed						autops perfori 1 ☐ Yes	ned? death?	?
ta	ician: Th certificate rector, pag	Be C	25. Was case referred to medical				26. Place of Dea	th (Check only or		
<u>=</u>	ysicii is cer direct	To B	examiner? 1 Tes 2 Mo	lospital: 1 🔲 Inpati	ent 2 ER/Outpatie	nt 3□ DOA Oth	er: 4 Nursing H	ome 5 Reside	ence 6 □Other (Sp	pecify)
0	9 Ph ter th	L:U	27. Manner of Death ↑ Natural 5 □ Pending	28a. Date of Inju	ary 28b. Time of Injury	of 28c. Injur Wor	y at k?	28d. Describe he	ow injury occurred	
<u>Ö</u>	andin ath. or: Af	atic	2 Accident investigation			M 1 🗆	Yes 2 □No			
Division of Vital Records,	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		jury - At home, farm, st tc. <i>(Specify)</i>	reet, factory, office		281. Location (Si City or Town	treet and Number or . n, State)	Hurai Houte Number,
0	itel o irs aft rel D		<u> </u>							
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier Certifying Phy (Check only one) Certifying Phy Description on the control of the certifying Phy Description on the certifying Phy Description on the certifying Phy Description on the certifying Phy Description on the certifying Phy Description on the certifying Phy Description on the certification of the ce	sician: To the best ner: On the basis of and manner st	of my knowledge, dea of examination and/or is ated	in occurred at the tir nvestigation, in my o	me, date and place prinion, death occu	, and due to the c rred at the time, d	ause(s) and manner ate and place, and d	ue to the cause(s)
	thin 2 than 2 than mple	Med	30h Signature and tifle of certifier			29c. Licens			9d. Date signed (Mo	
	, <u>1</u> <u>1</u> <u>1</u> <u>1</u> <u>1</u> <u>1</u> <u>1</u> <u>1</u> <u>1</u> <u>1</u>		Alexander	M-D.		D-	38750	4	05-31	- 2005
/	11/	1	30. Name and address of person who co	ompleted cause of	death (Item 23a) (Type	, Print)			A 4 =	7.1.
k	DT TO		30. Name and address of person who compared to the state of the state	BM-	709. B	ASTERN	1 0521	D -	MD-	21221.
		ate	31. Date filed (Month, Day, Year)	9 2005 Regist	f's Signature	breeze				
	Regist	rar	ט אוטנ	W COOS	KRUAU AV	7				

DHMH 17 Rev 1/2001

			State of Maryland / Department of Healt 1 - State Registrar Certificate of Deal	
				2. Date of Death 3. Time of Death
	Physicia	an	1. Decedent's Name (First, Middle, Last) Camille Marie Kraetzer	Month Day Year
	/Medic			May 28, 2005 11:20 A M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Local	
			Beveria rark denebra rradical	na Park Anne Arundel Co.
	Funeral		1 M 2 F Yrs. Months Days Ho	urs Min. (Month, Day, Year) Country)
	Director		143-18-6601 85 Yrs.	Feb. 16,1920 Pennsylvania
	land wc		10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	Mary	ō	Maryland Dundalk Dun	dalk 1 □Yes 2 🖔 No
	the 28a	Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
	3a or			21222 United States
	Jeath me 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispani	ic Origin? (Specify Yes or No- exican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
(0	rite	Fur	Armed Forces? If Yes, specify Cuban, Me 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No 1 □ Yes 3 ☒ No 1 □ Yes 2 ☒ No Sou	2
g	hours after death with the Maryland turel', or Iteme 23s or 28s-f show Il Exscriper must be notified at	by	3 🗓 Widowed 4 □ Divorced Year or Dates:	ecity: Specify: White
21215-0036	C1 0 U	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired)	16b. Kind of Business/Industry
2	d within 7 jiene. r than "n If e Mad	npie	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	
2	Hygien Hygien kther th	Co	2 Years Credit Collec	
p	d a la	Be	17. Father's Name (First, Middle, Last)	Mother's Name (First, Middle, Maiden Sumame) Lucia Lardieri
yla		ို	Angelo Pucciarella	
Maryland	d 2 should h and Mer 7 is marke treumatic	X S	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and N</i> Deborah Bach (Daughter) 7722 Trappe Roa	Jumber or Rural Route Number, City or Town, State, Zip Code) .d Dundalk, Maryland 21222
	and ealt m 2	11. 13		Date 20c. Location - City or Town, State
ore	Pages 1		1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State	
Ē			'4 □Donation 15 □Other (Specify) Hilltop Service Cor	
Baltimore,	permit. Departr Importu any inji		21. Signature of Juneral Service Licenses 22. Name and Address of Funda-Ruck Fu	ineral Home of Dundalk, Inc.
	707 e d		(/ 1/20gm (-) 222 Wise Av	ch as cardiac or respiratory arrest Approximate
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart faither. List only one cause on each line.	re. Dundalk, MD ch as cardiac or respiratory arrest. The structure of Dundalk in the structure of the stru
	Physician		Immediate Cause (Final disease or condition resulting in death)	hours
	/Medical Examiner		Due to (3 x a consequence of):	
И			Sequentially list conditions, b. Due to for at a consequence of):	months unk now
	ed isit	Examiner	If any, reading to immediate cause. Enter Underlying Cause (Disease or injury	unknows
_	and and	xan	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
760,	te be executed ysician and ne burial-transit	calE	atherosclerosic Va	iscular disease years
687	e K			
	death certificat e attending phy od for use as th	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant	23d. Date of delivery
Вох	atter after	ciar	in the past 12 months? 1 ☐ Yes 2 No ☐ Horizon at 1 ☐ Yes 2 ☐ Yes 2 No ☐ Horizon at 1 ☐ Yes 2 ☐ Yes 2 No ☐ Horizon at 1 ☐ Yes 2 ☐ Yes 2 No ☐ Horizon at 1 ☐ Yes 2 ☐ Yes 2 No ☐ Horizon at 1 ☐ Yes 2 ☐ Yes 2 No ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Ye	Month Day Year
0	0 0 2	ysi	9 ☐ Unknown	Direction of the Control of the Cont
₽.		by Pi	Part II. Other significant conditions contributing to death out not resulting in the didenting cause given an	Part I. 23e. Did tobacco use contribute to the cause of death?
rds,	quires n sign	d b	remote subtural hematoma, ario	1 Yes 2 No 3 Probably 4 Onknown
Record	w requ	Completed	fibrillation, chronic dianher	24a. Was an autopsy autopsy findings available prior to completion of cause of
Re	he lav e has age 2	E		autopsy performed? death? 1 \(\) Yes \(2 \) No \(\) No
Vital		O	25. Was case referred to medical 26.	Place of Death (Check only one)
>	Physicien: rthis certific ral director,	O B	examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other.	▼Nursing Home 5 Residence 6 Other (Specify)
of	ding Ph. After thi funeral	n: T	00 D 11 D 10 D 11 D 10 D 11 D 10 D 10 D	28d. Describe how injury occurred
io	ttending f death. stor: After the funer	atio	1 Natural 5 Pending (Month, Day Year) Injury Work 1 Yes	× No fell at home
Division	or Attendate death	ific	3 Suicide 4 Homicide 3 Suicide 4 Homicide 4 Homicide 4 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Ö	tel or s afte al Dir	Certification:	nome -address unkno	wn Dundalk, MD
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.			ate and place, and due to the cause(s) and manner as stated. n. death occurred at the time, date and place, and due to the cause(s)
	ths H in 24 the F	Medical	one) and manner stated.	
	To T To T	Σ	29b. Signature and title of certifier 29c. License nun	
•	1/	Y		91955 6-1-05
Ŷ	6		30 Name and address of person who completed cause of death (Item 23a) (Typer Print)	hway rullersville MD
			33 Name and address of person who completed cause of death (Item 23a) Type Print) Place Ca Elon MD 8601 VeR (ans/type) 31. Date filed (Month, Day, Year) 32. Registrar Signature JUN 0 2 2001	Tiway - west ville all
	St	ate	31. Date filed (Month, Day, Year) 32. Registrar Signature	0 21108
	Regist	rar	IIIN IZ ZUU Flanting o his.	

John Kendrick Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. anend/unpend item/19b, 2a, 27, 28a-f, pentil MF (345, 77/7/5 TT State of Maryland / Department of Health and Mental Hygiene 05-03587 RPD For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 24, **Physician** MHOD 2005 KENDRICK 2238 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. NIA University Hospital Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, 04. 28 -**Funeral** Months 1**Ø**M 2□F 24. 56.4406 Usual Residence of Decedent Director Yrs Maryland 10a. State 10b. County 10c. City, Town or Location show 10d, Inside City Limits treumatic event, the Medical Evaniner must be nutitive Completed by Funeral Director BALTIMORE 1 ₹Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3725 EDMONDSON AVENUE 21229 Items 23a USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 □ Yes 2 **M** No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 ŏ 1 Yes 2 No Specify: 3 Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CARPENTER 10 TH GRADE NA HOME IMPROVEMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be I and Mental F should be JOHN KENDRICK GENEVA JOSEPH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 SISTER) item 27 DOROTHY BROWN 10008 1008 W. Lanvale St (1st F1.) Baltimore, MD 21217 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ö <u>=</u> 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ permit. Page Department of Importent: If any injury or ang e. ^¹ 4 □ Donation 5 □ Other (Specify) Molk. TM 06.01.05 BALTO. MD 21. Signa ure of Funeral Service License VAUGHN C. GREENE FUNERAL SERVICE angh 5151 BALTO NATI PIKE BALTO MO 23a. Part1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Blunt Force Head Injuries with Complications disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Director (or as a consequence of The law requires that the death certificate be executed Due to (or as a consequence of) burial-Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. 1 the 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1

▼ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 🗆 No or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Appatient 2 ER/Outpatient 3 DOA Other: Yes 2 No Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 Natural 5 🗌 Pending s after deurel Director: After 1 ☐ Yes 2 📉 No investigation 6:50 P 2 Accident Mary 14, 2005 Subject was assaulted 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3925 Editordson Ave 4X Homicide Scene Baltinore, MD within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 [XMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME May 25, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 Pamela E. Southall, MD

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUN 0 2 2005

3 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 1:10 A M 30 2005 Donald Shortt Kennedy May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Towson If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2□F Months Days Yrs. Director CA 215-14-8281 Usual Residence of Decedent 10c. City, Town or Location 10d. fnside City Limits 10a, State 10b. County Itam 27 is marked other than "netural", or Itams 23s or 28s-f show other treumstic event, the Medical Evanting must be routified at 1 ☐ Yes 2 No Director MD Baltimore Perry Hall 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 4500 G Talcott Terrace 21128 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 DXYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Property Management of Real Estate Dept. al Hygiene. Efementary/Secondary (0-12) Coflege (1-4or 5+) Vice President 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) is marked of Adele Madison Shortt James Martin Kennedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Lillian Brown Kennedy/Wife 4500 G. Talcott Terrace, Perry Hall, MD 21128 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Importent: If Its any injury or of once. 6/3/05 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD Bryan W. Cla 22. Name and Address of Facility 21. Sign Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 Clary Approximate fnterval Between Onset and Death 23a, Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Squa mous Cell Carcinoma Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown s been signed by t 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy perform 22 No 2 No 1 Yes Hospitel or Attending Physicien: tor: After this certific the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 Dether (Specify) Hospice 2 No 1 🗌 Yes Certification: To 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Naturaf 5 Pending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 📭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature/and title of certifier 29c. License number Joron Black in D May, 30, 2005 D0061199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST, Touson, MD 21204 . 6601 Black North Charles 32. Registrar's Signature 31. Date filed (Month, Day, Year) JUN 0 2 2005 State

DHMH 17 Rev 1/2001

Registrar

Smale Kennedy May 30, 200

		1	For State Registrar	State of	f Marylar		rtment of I tificate of		and Me		jiene	05	18471	J
	9		Decedent's Name (First, Middle						2	Date of Dea Month	Day	Year	3. Time of Death	
	Physicia /Medic	al	Mildred Dor							May	_25 , 20	005	6:32P	<u>~</u>
	Examin	CI	4a. Facility Name (If not institution				4b. City, Town,		of Death		4c. County			
			Upper Chesapeak 5. Social Security Number	e Medical	7. Age (In yrs.		BeI If Under 1 Year	If Under 2		. Date of Birth	1	ford 9. Births	place (State or Forei	gn
	Funeral Director		189-34-9891	1□M 2∏F		2 Yrs.	Months Days	Hours	Min.	(Month, Day lar 28	1 943		nsylvania	
	p.		Usual Residence of Decedent		100 0	ty, Town or Lo	nation				•		Od. Inside City Limit	te
8	anylar show	5	10a. State 10b. County	1	106. 01								1 ☐ Yes 25 € N	
). W	the M	ecto	Maryland Harfo	ord		Jarr	ettsvil	<u>le</u>	-	1	10g. Citizen of	What Cou		_
_	death with the Maryland ms 23a or 28e-f show rmust be millind at		3701 Old Federal	l Hill Ros	ad			1084			-	ISA	•	
	death ms 2	Funeral Director	11. Marital Status		edent Ever in U	J.S. 13. V	Vas Decedent of Yes, specify Cub	Hispanic Orig	gin? (Speci	ify Yes or No-	14. Rad		can Indian,	
9	after or its	/Full	1 ☐ Never Married 2X Marr		2 N O		☐ Yes 25 No		, 1 00110 111	ouri, oto.,		y: Whi		
8	hours after turel', or fte	d by	3 Widowed 4 Divorced	Year or D	ates:		lent's Usual Occu				16b. Kind of B			
1 5-	in 72 "net	Completed	15. Deceden (Specify only higher	st grade completed)		(Give	kind of work done OO NOT use retire	during most ad)	t of working	7	TOD. KING OF D	43111033411	dustry	
212	d within jiene. r then "	mo	Elementary/Secondary (0-12)	College (1	1-40r 5+)	Home	maker				Own	Home		
ğ	be filed within 72 hours after death with the Marylan ital Hygiene. Id other then "neturel", or items 23a or 28e-f show event, the Medical Examiner must be multiped at	Be C	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name (First, Middle,	Maiden Sumar	пө)		
<u>yla</u>	2 should be and Mental is marked o raumatic eve	2	Theodore Metz							Lechn			0-1-)	
Maryland 21215-0036	12 sh h and 7 is m traum		19a. Informant's Name/Relations Raymond T. Keen		nd.		g Address (Stree						MD 21084	
	is 1 and 2 should of Health and Men item 27 is marke other traumatic		20a. Method of Disposition		20b.		sition (Name of natory or other pla		Da Da		20c. Location			_
) <u>F</u>	Pages ent of nt: if i		1 ☐ Burial 2 🕅 Cremation 4 ☐ Donation 5 ☐ Other (S		State		ematory		05/26	/05	Baltimo	re. I	Maryland	
/25/05 Baltimore,	perrii. Pages Department of I Importent: if its any injury or o		21. Signature of Funeral Service	(Repsee			Name and Addr Sematici 99 Frede	-						
1.) =			Thomas Grego 23a. Part 1. Enter the disease, or	complications that of	aused the dea							ı yıaı	Approximate Interval Between	_
	Physician		shock, or heart failure. List Immediate Cause (Final	only one cause on e	each line.	Aco	y thmi	ac.				1	Onset and Death	
	/Medical		disease or condition resulting in death)	a Due to	(or as a conse		7 100	us						
W	Examiner		Sequentially list conditions,	b. Liv		elas	tasis						2 Weeks	
ーXで る	ad sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	4 1.	(or as a conse	quence of):	tacia						1 libek	<
9 .	xecut and	Examine	that initiated events resulting in death) Last	U	or as a conse		واحلاا						x woon	
#386621 68760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai E		Br	east	Cano	cer					6	1 Years	ĵ
	rtificat ng phy as th	a a	ICCCNALC.											
Вох	eath certific attending p for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live t	tcome of pregr birth 2 Fet	al death 3□	Ectopic pregnan					ate of deliv	ery Day Year	
o.	ne dea the al	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregr 9□Unkn	nant at time of lown	death 5	Other (specify)						·	
Dorothy scords, P.O.	es that the de igned by the a be detached to		Part II. Other significant conditi	ons contributing to d	leath but not re	sulting in the u	nderlying cause g	jiven in Part I.		23e. Did to	bacco use con	tribute to	he cause of death?	
√oγ rds,	puires n sign ald be	d by								1 🗆 Y	′es 2□No	3 □ Pro	bably 4 Unknov	٧n
Do	aw require s been sig 2 should b	Completed								24a. Was autop	an 24b.	Were aut	opsy findings availat	ole of
		mo								perfoi	med? 2 X No	death? 1 ☐ Yes	ompletion of cause of 2000 No	
ည် <u>Eti</u>	<u>=</u> = 5	Be (25. Was case referred to medica examiner?		1012	27			of Death	(Check only o	ne)			-
10	Phys this al di	2	1 Yes 2 No	Hospital: 1 🗆 28a. Date		ER/Outpatier 28b. Time of	IL SEL DOA				ience 6 🗆 Oti		fy)	_
M. Id red	ng fter	tion	1 Matural 5 ☐ Pendi	/Ador	nth, Day Year)	Injury	W	ork? ⊒Yes 2	,					
S	Attendi	Certification:	3 Suicide 6 Could	not be 28e. Place	e of Injury - At I	home, farm, str	eet, factory, office	9	28	Bf. Location (S City or Tox	Street and Num.	ber or Rur	al Route Number,	
ene	ital or irs afte rei Dir led in													
Kel	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medicai	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physician: To the Examiner: On the band man	e best of my kr pasis of examin nner stated.	nowledge, deat nation and/or in	n occurred at the vestigation, in my	time, date an opinion, dea	nd place, ar ath occurre	nd due to the o d at the time, o	cause(s) and m date and place,	anner as : , and due !	stated. to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and tale of certifie	31				nse number		- 1	29d. Date signe			
	Λ		MAN	7			Print) Wood R	3185	56		05/2	5/2	005	
-	4		30. Name and address of person	4Λ	se of death (Ite	am 23a) (Type,	Print)	ایم ار	- 10	1 2-1	Air M	T .		
			Desh P. Shi	arma, M	Registrar's Sign	スライフ	wood K	, a, st	C. 10	b, Del	711	10 0	4017	
	Sta Regist	ate rar	IIIN n 9		2									

DHMH 17 Rev 1/2001

ORIGINAL

Robert A. Krier 05-03542 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. MUN State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** KoBERT A. May 2005 2205 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 4502 Mainfield Avenue Baltimore Baltimore City If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 12M 20F Months Days 110-22-576 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f ehow other treumatic event, the Mucheal Examiner must be nutilised at MD 1 Yes 2 □ No BALTIMORE **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? MAINField 21214 U.S.A 4502 Items 23e 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No U.S If Yes, Give Year or Dates: ARM Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married ٥ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: LuhiTe Completed by 3 Widowed 4 Divorced ARMY "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) MD NIA 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental ! Pages 1 and 2 should be ELIZABETA Charles KRIER 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other tree QDCs. PK BUD. KRIER 20b. Place of Disposition (Name of cometery, crematory or other place) KENMORE, NY Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/2/05 tores T * 4 ☐ Donation 5 ☐ Other (Specify) Owi NGS 22. Name and Address of Facility Stella Evaena & Herre (++T) 21. Sonature of Funeral Service Licensee HARTLEY Miller Bolto No 21234 7527 ha : Ford KD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, splock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final etherosc Physician lerotic carol disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a noneaquence of): Examiner use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably ﴾ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 🗌 Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 sether (Specify) Scene Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 □ No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainteness as success.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME May, 23, 2005

12

State Registrar 31. Date filed (Month, Day, Year)

30-Name and address of person who completed cause of dea

32 Degistrar's Signature

2.

111 Penn Street Baltimore, Maryland 2120

(Item 23a) (Type, Print)

Pnysician /Medical Examiner

Physician

Examiner

Funeral

Director

ь

al Hygiene.

The I

5 Department of Important: If it any injury or o

ould be

the Medical Exam

Maryland 21215-0036

Baltimore,

P.O. |

Division of Vital Records.

/Medical

Directo

Completed by Funeral

Be

2

The law requires that the death certificate be executed burial-transit as the signed be det page death.

Examiner Physician/Medical Be Completed by Certification: To Medicai

25. Was case referred to medical 27. Manner of Death

Hospital or Attending Physician: after death Director: within 24 hours a

31. Date filed (Month, Day, Year) State JUN 0 2 2005 Registrar

examiner?

1 Natural 2 Accident

3 T Suicide

29a. Certifier

4 🗍 Homicide

(Check only one)

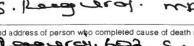
29b. Signature and title of certifier

1 Yes 2 No

5 Pending

investigation

6 Could not be determined



29c. License number D-53720

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home Star Residence 6 Other (Specify)

28d. Describe how injury occurred

Belcair, My

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) may 2005

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. fagura, 602 S. Atwass Pas #166

32. Registrar's Signature

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28a. Date of Injury (Month, Day Year)

			1 = For State Registrar	State of Ma		partifient of learning			ene200	5	18473		
	Physicia		1. Decedent's Name (First, Middle, Last, Helen Dolores Ke					2. Date of Death Month May 27,		ear	3. Time of Death		
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Death	<u> </u>	4c. County of	Death			
П			Lorien Frankford				imore						
	Funeral Director		219-22-10/8	7. Age	(In yrs. last birth	Months Davs	Hours Min.	8. Date of Birth (Month, Day, 1	911 N	Birthpla Count Jary	ace (State or Foreign ry) Land		
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10	d. Inside City Limits		
	Maryll faho leda	or	MD N/A		Balt	more					1√Yes 2 No		
	r 28a	rec	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wha	at Count	ry?		
	h with	a D	4506 Furley Avenue	<u>:</u>		212	206		U.S.A.				
' O	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mantal Hygiene. Importent: If item 27 is marked other than "netural", or Itams 23a or 28a-f ahow eny injury or other treumetic event, I've Medical Examinar must be notified at 200e.	by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N		13. Was Decedent of If Yes, specify Cub		ecify Yes or No- Rican, etc.)		America White, e			
ဗ္ဗ	ral', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:	Wh	ite		
21215-0036	in 72 ho n "netur de dical	Completed	15. Decedent's Edu (Specify only highest grad			ecedent's Usual Occu Give kind of work done ife. DO NOT use retire	pation during most of work ad)	ting 10	5b. Kind of Busir	ness/Ind	ustry		
212	d with giene or tha	ШO	Elementary/Secondary (0-12)	College (1-401 5		omestic Wo	rk		Private	e Hoi	mes		
힏	e file al Hyg l othe vent,	Be C	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma					
<u>la</u>	Manta	To	Peter Joseph Kelly	7			L	(Nellie)					
Maryland	2 sho and ls mu		19a. Informant's Name/Relationship (7)		1	Mailing Address (Stree			•				
	and lealth m 27 her tr		Raymond Kelly/Neph	1ew		08 Laurel							
Baltimore,	ges 1 t of H ff ite or oti		20a. Method of Disposition 1 Burial 2 Cremation 3 F	Removal from State	l	isposition (Name of crematory or other pla			Oc. Location - Cit				
Ë	t. Pa rtmen rtent: njury	1	' 4 □ Donation 5 □ Other (Specify)		New Ca	thedral	5/28				Maryland		
Ba	parmi Depa Impo eny ir		21. Signature of Fuheral Service Licens	A			ir Road B				Home Inc. 21206		
П			23a. Parl 1. Enter the disease, or comp sheck, or hear failure. List only o	ications that caused ne cause on each lin	the death. Do no				st,		Approximate Interval Between		
	Physician	ř	Immediate Cause (Final disease or condition	Pre	JM JA A	Aspi	ration Pno	eumonia			Onset and Death		
	/Medical		resulting in death) a										
	Examiner		Sequentially list conditions,	o. — — — — — — — — — — — — — — — — — — —	1, 22 100	~					41-14		
7	ed sit	lne	if any, leading to immediate cause Enter Uniter ying Cause (Disease or injury	Due to (or as a	a consequence of	:							
V -	xecut and ıl-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a	a consequence of	:					_		
38760,	ficate be executed physician and is the burial-transit	dical	(d									
Box 68	death certifica attending ph d for use as th	00	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		3□Ectopic pregnand	2		23d. Date o		•		
P.O. B	law requires that the death certif as been signad by the attending 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ※ No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown		5 Other (specify)	-		Month		Day Year		
	res that ignard b	by Pr	Part II. Other significant conditions co	ntributing to death be	ut not resulting in	he underlying cause g	ven in Part I.	23e. Did toba	icco use contribi	ute to the	e cause of death?		
Records,	w requires been sign should be		Dementia					1 🗆 Yes	2XNo 31	☐ Proba	ably 4 🗆 Unknown		
ec	e faw I has by	Completed						24a. Was an autopsy	prio	ir to com	sy findings available pletion of cause of		
=	Th ate pag	S						perform 1 Yes 2		th? Yes :	2 □ No		
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	lospital:		- Ot		th (Check only one			7-0-0		
ot	90 × =	J.	1 Tes 2 No 27. Manner of Death	1 ☐ Inpatie	nt 2 ER/Outp	atient 3 DOA	4 Hursing H	ome 5 Residen		(Specify))		
on	ing Afte une	ton	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da)	Year) Inj	ury Wo	ork?]Yes 2 □No		,,				
Division	r Atten ler deat irector: i by the	ertification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc		n, street, factory, office		28f. Location (Stre City or Town,	et and Number State)	or Rural	Route Number,		
	To the Hospital or within 24 hours afte To the Funerel Dir completely filled in	Medical Ce			examination and	death occurred at the to investigation, in my							
	o the	₹ Z	29b. Signature and title of certifier	11	1	29c. Licen	se number	29	d. Date signed (/	Month, E	Day, Year)		
	C > F 0			11.	,) .	7 0	43386		5.27	.05			
	Λ		30. Name and address of person who c	ompleted cause of d	eath (Item 23a) (7	ype, Print)							
	1)		Duniel R.	1 toward	un	1714 6	Eutem P	Iner Bu	(Himore	w	7 21217		
	Sta		31. Date filed (Month, Day, Year)		ar's Signature								
1	Regist	ar	JUN 0 2 2	UUS Steen	w &	Sperke							
DH	IMH 17 Rev 1/2	001			ORIG	INAL							

State of Maryland / Department of Health and Mental Hygiene,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physicia /Medic Examine	al
Funeral Director	

Landis, Margaret

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: A completely filled in by the fu State Registrar

	1 - State Registrar	Certificate of Death	Reg. No.	:005	184/4
	Decedent's Name (First, Middle, Last)		2. Date of Death . Month Day	y Year	3. Time of Death
an al	MArgaret I. Lar	ndis	May 30	2005	4:20 AM
er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c.	County of Death	
	Franklin Square Hospital Co	enter 15 osedale	10	baltima	ore
	5. Social Security Number	Months Davs Hours Min.	8. Date of Birth (Month, Day, Year)	Coule	ace (State or Foreign Virginia
	217-24-7703	Yrs.	July19,1	924 West	virginia
	Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Location		10	Od. Inside City Limits
ō	MD Baltimore	Essex			1 ☐ Yes 2 € No
rect	10e. Street and Number	10f. Zip Code	10g. Citi	izen of What Coun	try?
Completed by Funeral Director	627 South Marlyn Ave,	21221	US	A	•
era	11 Marital Status 12. Was Decedent Ever in U.S	. 13. Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	14. Race - America	
Ē	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼ No	If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, White, 6	
by	3 XWidowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2🔀 No Specify:		Specify: Whi	te
ted	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of workir	16b. Ki	ind of Business/Ind	lustry
nple	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)		b	
Con	12th	Homemaker		n home	
Be	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden	Sumame)	
ဥ	FRank Biby		Painter		
	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural 2317Kingarms Drive			Code)
	Owen LAndis /son				- Chat-
	20a. Method of Disposition 20b. Pla	nce of Disposition (Name of metery, crematory or other place) Lair Memorial 6/2/		ocation - City or To lair MD	
	'4 □Donation 5 □ Other (Specify)		US BE	TOTT ME	
	21. Signature of Funeral Service Licenses	22. Name and Address of Facility Con:	nellyFune	eralHome	ofEssex
	1. Pery Conselle	300 Mace Ave. B	altimore	MD 2122	21
	23a. Part1. Enter the disease, or constant caused the death shock, or heart failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition				
	resulting in death) Due to (or as a consequence)				
_	Sequentially list conditions, if any, leading to immediate	Artery Disease			
ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	arice or).			
хап	that initiated events c. Due to (or as a consequence of the consequenc	ence of):			
al E	333 10 (5) 33 2 33 10 (4)	3.130 07,1			
Medical Examiner	d				
	IF FEMALE: 23c. If yes, outcome of pregnan	CV		23d. Date of delive	n/
clan	in the past 12 months?	death 3 Ectopic pregnancy			Day Year
ıysi	1 Yes 2 No 9 Unknown				
Completed by Physician/	Part II. Other significant conditions contributing to death but not resul	ting in the underlying cause given in Part I.	23e. Did tobacco ι	use contribute to th	e cause of death?
d b	Acute Renal Failure		1 ☐ Yes 2	□No 3 □ Proba	abiy 4 Unknown
ete		esponse Syndrome	24a. Was an	24h Were autor	osy findings available
ф	JATEMIC INFORMATION N	esponse synatome	autopsy performed?	prior to con death?	npletion of cause of
	25. Was case referred to medical	00 Plane of Parth	1 Yes 2 10	1 🗆 Yes	2 No
o Be	examiner? Hospital:	26. Place of Death 27. Place of Death 28. Other: 4 □ Nursing Hon	ne 5 Residence	C Dothar (Casait	2)
. To	27. Manner of Death 28a. Date of Injury	28b. Time of 28c. Injury at 2	28d. Describe how injur)
tlor	1 atural 5 Pending (Month, Day Year) 2 Accident investigation	Injury Work? M 1 ☐ Yes 2 ☐ No			
fica	3 Suicide 6 Could not be 28e. Place of Injury - At hor		28f. Location (Street an		Route Number,
ert	4 Homicide determined building, etc. (Specify)		City or Town, State	"/	
alc	29a. Certifier 1 Certifying Physician: To the best of my know	rledge, death occurred at the time, date and place, a	and due to the cause(s)) and manner as st	ated.
Medical Certification:	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	on and/or investigation, in my opinion, death occurre	d at the time, date and	d place, and due to	the cause(s)
M	29b. Signature and title of certifier	29c. License number	29d. Dat	te signed (Month, L	Day, Year)
/	ble to Trousin	M D = 511177	05	- An-	15

DR Glenn Meininger 31. Date filed (Month, Day, Year) JUN 0 2 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. Glenn Meininger 7000 Franklin Square Drive, Boltimore, MD. 21237

31. Date filed (Month, Day, Year) 22. Registrar's Signature

		4	For State Registrar	State of I	Marylan	-	artment rtificate			ind Me		giene Reg. No.	005	18475
	Physici	an	1. Decedent's Name (First, Middle, Last Eva. Lynck	st)						2	2. Date of Dea Month May	2 ^{Day}	2 o	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and numb	er)		4b. City, To			f Death	-	4c.	County of De	
			Haven Nursing Home		A = = (/ = = =	t	Balt If Under 1	timor	e If Under 2	04 Hrs. c			NA .	
L	Funeral Director		427-18-8076	ex □ M 2 XX F	Age (In yrs. 87	Yrs.		Days	Hours	Min.	B. Date of Birth (Month, Day 07–19–19	/, Year)		Birthplace (State or Foreign Country) SISSIPPI
	and w	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	Mary F sho	to	MD NA			Ba	ltimore							1 XYes 2 □ No
	th the	Funeral Director	10e. Street and Number				10f. Zip C	Code				10g. Citi	zen of What	Country?
	ath wi	rai	3939 Penhurst Avenue				2121					USA		
	er des	inne	11. Marital Status 1 ☐ Never Married 2 ☒ Married	12. Was Decede	s?	S. 13.	Was Decede If Yes, specif	nt of His y Cuban	panic Orig n, Mexican,	jin? (Spec , Puerto Ri	ify Yes or No- ican, etc.)		14. Race - Ai Black, W	nerican Indian, hite, etc.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show the Medical Examinar must be notilied at	þ	3 Widowed 4 Divorced	1 Tes 2 If Yes, Give Year or Date			1 □ Yes 2	No 🖸	Specify:				Specify: B	lack
S O	72 ho	Completed	15. Decedent's Ed (Specify only highest gra			(Give	dent's Usual kind of work	done di	urina most	of working	,	16b. Kii	nd of Busine	ss/Industry
121	within nne. ihan "	mpl	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT use							
р О	filed y Hygie other i	e Co	10 17. Father's Name (First, Middle, Last)				Domes		18. Mother	r's Name (First, Middle,	Maiden	Hom Sumame)	es
lan	Aental Aental rked tic ev	To Be	Gus Deer							Or	a Deer			
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Itam 271s marked other than "natural", or Itams 23e or 28e-f show any injury or other traumatic evant, the Medical Examinar must be notified at once.		19a. Informant's Name/Relationship (Route Numbe			, Zip Code)
e, S	1 and Health am 27 ther tr		Charles Crossley/ Nep 20a. Method of Disposition	hew	20b. P	_ 1403 S			e Mc	Comb,	Mississi			or Town, State
nor	ages int of h t: # Ita y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify		ite C	emetery, crei enlawn	natory or oth	er place		5-04-0!				lississippi
慧	mit. Poartme		21. Signature of Funeral Service Licer		o.c		2. Name and				3	DU	illitice, I	пээтээтрүг
Ö	Ped In Ped Ped Ped Ped Ped Ped Ped Ped Ped Ped		Junella Jon	رما			Wylie F	unera	al Hom	e 638	N. Gilmo	or St	. Balto	,MD 21217
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cau one cause on eac	sed the death n line.	h. Do not ent	er the mode	of dying	, such as o	cardiac or	respiratory ari	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Cc	india	0 01	rrythe	mia	2					30 mines
Н	Examiner		1	a. Candiac arrythemias Due to (or as a consequence of): b. Atheroscientific heart disease Due to (or as a consequence of):									5 423	
	البالية	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying										,	
V	ecuted and -transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to /or		uanaa afti								
8760,	death certificate be executed the attending physicien and at for use as the burial-transit			Due to (or	as a consequ	derice or).								
9	ificate g phys	edic		d								_		
Вох	eath certific attending p I for use as I	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna		Ectopic pred	onancv				2	3d. Date of	,
	the att	Physician/Medical	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		t at time of d		Other (spec		<u>-</u>				Month	Day Year
P.O.	law requires that the de as been signed by the a 2 should be detached f		Part II. Dther significant conditions of	ontributing to deat	h but not res	ulting in the u	nderlying cau	use give	n in Part I.		23e. Did to	bacco u	se contribute	to the cause of death?
Vital Records,	w requires been sign should be	ed by	Demention								1 □ Y	es 2[□No 3□	Probably 4 Unknown
900	e law requ has been je 2 shoule	Completed									24a. Was a		24b. Were	autopsy findings available o completion of cause of
<u>~</u>	: The cate ha	Com								_	perfor		death 1 🗆 Y	?
Vita	Physician: r this certifica ral director, i	Be	25. Was case referred to medical examiner?	Hospital:		55/0	-0-0	Otho			Check only or	/		
o	y Physer this eral di	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of (Month,		ER/Outpatier 28b. Time o		c. Injury	at		e 5 🗆 Resid 3d. Describe h			pecify)
ion	Attanding or death. ector: After by the fune	atlo	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	1	Day rear)	Injury	М	Work' 1 □ Y	es 2 🗆 N	No				
Division	in the	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of	Injury - At he etc. (Specify	ome, farm, str	eet, factory,	office		28	If. Location (S City or Tow			Rural Route Number,
	To tha Hospital or At within 24 hours after d To tha Funaral Direct completely filled in by	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exer	ysicien: To the boniner: On the basi	s of examina	wledge, deat tion and/or in	h occurred at vestigation, i	t the time	e, date and inion, deat	d place, an	nd due to the o	ause(s) date and	and manner place, and d	as stated. ue to the cause(s)
	within To the compl	Me	29b. Signature and title of certifier						number					nth, Day, Year)
}				y .	KNE	SAlmo		D3	0401	4		5	47/40	ics
_	2		N 10 231111113	completed cause	of death (Item	7 hcsp	Print)	301	Sat	n ch	crles s	shec	or B	altimore movilse
	Sta Registi		31. Date filed (Month., Day, Year)	2005 32. Re	strar's Signa	ture /	Joseph	,						

ledical aminer		Owen Wayne L	Last/	C C844_6/62			2. Date of Dea Month	Day Year	3. Fime of Death (
	4a. F	acility Name (If not institution, g		er)	4b. City, Town, or			4c. County of Dea	•
	6	- ood somor				MER			N/A
erai ctor	51	6-22-8097	i. Sex 7. iX M 2 □ F	Age (In yrs. last birthday 83 Yrs.	Months Days	If Under 24 Hrs Hours Min		r, Year) C	rthplace (State or Foreign Junitry) Linnesota
or or	10a.	State 10b. County		10c. City, Town or I		-			10d. Inside City Limits 1 ☐ Yes 2 No
Director		ryland Harfo	ora	Belcamp	10f. Zip Code			10g. Citizen of What C	ountry?
al D		1412 Dalmation	n Place		21	017		USA	
or other treumatic svent, the Medical Examinational Perporting at or other treumatic svent, the Medical Examination and To Be Completed by Funeral Director	11.	Marital Status I □ Never Married 2 ☑ Marrie B □ Widowed 4 □ Divorced	12. Was Decede Armed Force d 1 Types 2 If Yes, Give Year or Date	□No	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	Specify:	
completed	E	15. Decedent's (Specify only highest lementary/Secondary (0-12)	Education grade completed) College (1-4)	(Giv	edent's Usual Occup le kind of work done DO NOT use retired	during most of w	orking	16b. Kind of Busines	s/industry
Con	_		2		Military	10. Mathada M	ame (First, Middle,	U.S. Gove	rnment
To Be	17.	Father's Name (First, Middle, La Edward Golde:				Bess:	ie Elida	Larson	
E E		. Informant's Name/Relationshi			are more reduced and a second		1003-22013-23010	r, City or Town, State,	- C-42-1/427
or other t		Lola Cole Lee / . Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		20b. Place of Disposers	position (Name of rematory or other place	сө)	Date	Maryland 20c. Location - City o	r Town, State
injury o		4 ☐ Donation 5 ☐ Other (Spe	ecify)	Arlingto				Arlington,	Virginia
any in		Signature of Funeral Service Li	1. Huca	1	22. Name and Addre McComas F 1317 Coke	sbury Ro	oad, Abin	gdon, Mary	land 21009 Approximate
ian ical	lm: dis	a. Part1. Entir the disease, or c shock, or heart failure. List o mediate Cause (Final ease or condition ulting in death)	a. Probe	sh line.	yo Care	ial -	Free	eTion	Un Consum
iner	Se	quentially list conditions,		· WE V C	Don.				
mIn.	cau	ny leading to immediate	Due to (or	as a cons vuence of):	01/20	6/16	\sim		UnEngun
e burial-transit		quentially list conditions, ny, leading to immediate isse. Enter Underlying use (Disease or injury t initiated events ulting in death) Last	c		01 / 7-Q	C 176	M		Untingwa
lcal		use (Disease or injury t initiated events	c	r as a consequence of): r as a consequence of): ome of pregnancy th 2 Fetal death that at time of death	B Ectopic pregnanc		M	23d. Date of d Month	
be detached for use as the but by Physician/Medical	IF 23	use (Disease or injury to initiated events ulting in death) Last FEMALE: D. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	c	r as a consequence of): r as a consequence of): ome of pregnancy th 2 Fetal death that time of death	B⊟Ectopic pregnanc S ☐ Other (specify)	у	23e. Did to	23d. Date of d Month obacco use contribute	elivery
pe 2 should be detached for use as the bur mpleted by Physician/Medical	IF 23	use (Disease or injury tinitiated events ulting in death) Last FEMALE: b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c	r as a consequence of): r as a consequence of): ome of pregnancy th 2 Fetal death that time of death	B⊟Ectopic pregnanc S ☐ Other (specify)	у	23e. Did to	23d. Date of d Month bbacco use contribute Yes 2 No 3 an 24b. Were prior t med?	elivery Day Year to the cause of death? Probably 4 (Denknown autopsy findings available o completion of cause of
pe 2 should be detached for use as the bur mpleted by Physician/Medical	Par	use (Disease or injury tinitiated events ulting in death) Last FEMALE: D. Was decedent pregnant in the past 12 months? 1	c	r as a consequence of): r as a consequence of): ome of pregnancy th 2 Fetal death that time of death	B⊟Ectopic pregnanc S ☐ Other (specify)	y ven in Part I.	23e. Did to 1 1 \(\) 24a. Was autoperfo	23d. Date of d Month bbacco use contribute res 2 No 3 an an 24b. Were prior to the contribute reset 1 Yere 2 Ano 1 Yere	elivery Day Year to the cause of death? Probably 4 Denknown autopsy findings available occupietion of cause of
Il director, page 2 should be detached for use as the bur To Be Completed by Physician/Medical	Par	Use (Disease or injury tinitiated events ulting in death) Last FEMALE: D. Was decedent pregnant in the past 12 months? 1	c	r as a consequence of): r as a consequence of): ome of pregnancy the 2 Fetal death of the strength of the st	B Ectopic pregnanc Other (specify) underlying cause grounderlying grounderlying grounderlying grounderlying cause grounderlying	y ven in Part I. 26. Place of D hen: 4 \(\subsection \text{Nursing}	23e. Did to 1 \(\) \(\	23d. Date of d Month bbacco use contribute fes 2 No 3 an an ssy rmed? 2 No 1 Y death 1 Y dene) dence 6 Other (S)	elivery Day Year to the cause of death? Probably 4 Denknown autopsy findings available o completion of cause of ?
Il director, page 2 should be detached for use as the bur To Be Completed by Physician/Medical	Par	Was case referred to medical examiner? I Manual San No. Manual San No. Manual San No. Manual San Pending investig inves	C. Due to (or d. 23c. If yes, outcome of the pregnare of the p	r as a consequence of): r as a consequence of): one of pregnancy the 2 Fetal death that time of death wh patient 2 FEK/Outpat Injury Loay Year) 28b. Time Injury	B Ectopic pregnanc Comparison Com	y 26. Place of Den: 4 □ Nursing ry at rk?] Yes 2 □ No	23e. Did to 1 \(\) \(23d. Date of d Month bbacco use contribute yes 2 No 3 an an symmed? 24b. Were prior to death 1 Yes the symmet of the symmet	lelivery Day Year to the cause of death? Probably 4 Denknown autopsy findings available ocompletion of cause of ease 2 \(\) No pecify)
by the funeral director, page 2 should be detached for use as the bur tiffication: To Be Completed by Physician/Medical	Par 25	Use (Disease or injury trinitiated events ulting in death) Last FEMALE: D. Was decedent pregnant in the past 12 months? 1	C. Due to (or d. Due to (or d. Live birt 4 Pregnar 9 Unknowns contributing to deal land) Hospital: 1 In In In In In In In In In In In In In	r as a consequence of): r as a consequence of): ome of pregnancy the 2 Fetal death of the state of the stat	DEctopic pregnance Other (specify) underlying cause gradular and the control of	y 26. Place of □ her: 4 □ Nursing ry at rk?] Yes 2 □ No	23e. Did to 1 \(\) \(23d. Date of of Month obacco use contribute fes 2 No 3 an an 24b. Were prior to death 2 No 1 You death 1 You dence 6 Other (S) now injury occurred	elivery Day Year to the cause of death? Probably 4 (Ahriknown autopsy findings available ocompletion of cause of ess 2 No
ely filled in by the funeral director, page 2 should be detached for use as the bur leal Certification: To Be Completed by Physician/Medical	Par 25 27.	Was case referred to medical examiner? Was case referred to medical examiner? Yes 2 No Natural Pending investig Accident Natural Natural tural	C	ras a consequence of): ras a consequence of): ome of pregnancy the 2 Fetal death of the state	BEctopic pregnanc Comparison of the comparison o	y 26. Place of D her: 4 \(\text{Nursing} \) ry at rk? Yes 2 \(\text{No} \) ime, date and place on interpretable on in	23e. Did to 1 \(\) 24a. Was autopered by 24b. Location (3 City or Towns and due to the coursed at the time.	23d. Date of of Month obacco use contribute fes 2 No 3 an an 24b. Were prior to death 22 No 1 Your death 1 Your death 25 No injury occurred Street and Number or wn, State)	lelivery Day Year to the cause of death? Probably 4 (Honknown autopsy findings available o completion of cause of? as 2 No Decify) Rural Route Number, as stated, ue to the cause(s)
ely filled in by the funeral director, page 2 should be detached for use as the bur leal Certification: To Be Completed by Physician/Medical	Par 25 27.	Was case referred to medical examiner? Was case referred to medical examiner? Yes 2 No Natural Pending investig Accident Natural Natural tural	C	ras a consequence of): ras a consequence of): ome of pregnancy the 2 Fetal death of the state	BEctopic pregnanc Comparison of the comparison o	y 26. Place of D her: 4 \(\text{Nursing} \) ry at rk? Yes 2 \(\text{No} \) ime, date and place on interpretable on in	23e. Did to 1 \(\) 24a. Was autopered by 24b. Location (3 City or Towns and due to the coursed at the time.	23d. Date of of Month obacco use contribute fes 2 No 3 an an 24b. Were prior to death 22 No 1 Your death 1 Your death 25 No injury occurred Street and Number or wn, State)	lelivery Day Year to the cause of death? Probably 4 (Honknown autopsy findings available o completion of cause of? as 2 No Decify) Rural Route Number, as stated, ue to the cause(s)
by the funeral director, page 2 should be detached for use as the bur tiffication: To Be Completed by Physician/Medical	Par 25 27 29 29	Was case referred to medical examiner? Was case referred to medical examiner? Yes 2 No Natural Pending investig Accident Natural Natural tural	C	ras a consequence of): ras a consequence of): ome of pregnancy the 2 Fetal death of the state	BEctopic pregnanc Comparison of the comparison o	y 26. Place of D her: 4 \(\text{Nursing} \) ry at rk? Yes 2 \(\text{No} \) ime, date and place on interpretable on in	23e. Did to 1 \(\) 24a. Was autopered by 24b. Location (3 City or Towns and due to the coursed at the time.	23d. Date of of Month obacco use contribute fes 2 No 3 an an 24b. Were prior to death 22 No 1 Your death 1 Your death 25 No injury occurred Street and Number or wn, State)	lelivery Day Year to the cause of death? Probably 4 Denknown autopsy findings available o completion of cause of? as 2 No Decify) Rural Route Number, as stated.

Dhysic	ian-	1 - State Registrar AMEND ITEM 1. Decedent's Name (First, Middle, Last	#19b PER]	FII G844 87	62/65°	e of l	Death	2. Date of D Month		3. Time of D
Physic /Medi Examir	cal .	4a. Facility Name (If not institution, give				-	Location of Deal	MAY		Year 155 1 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2
Funeral Director		Social Security Number 6. S		e (In yrs. last birthday 84 Yrs.			STOWN If Under 24 Hrs Hours Min.			9. Birthplace (State or PA
a-f show	tor	Usual Residence of Decedent	MORE	10c. City, Town or I	Location TIMORE					10d. Inside City 1 ☐ Yes 2
23a or 28. ust be rot	Funeral Director	10e. Street and Number 7920 SCOTTS LEV			10f. Zip		21208		10g. Citizen of	What Country?
th and Mental Hygiene. ?7 Is marked othar than "natural", or Itams 23s or 28s-f show traumatic evant, the Mudical Everting must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🂢 Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		. Was Deced If Yes, spec		spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	o- 14. Ra Bla Speci	ace - American Indian, ack, White, etc. ify: WHITE
ygiene. nar than "natu t, the Medica	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12	lucation de completed) College (1-4or 5	(Giv life.	edent's Usua re kind of wor DO NOT us UTICIA	k done d e retired,	luring most of wo.	rking	HAIR C	Business/Industry
and Mental Hygiene. Ia marked othar than aumatic evant, the M	To Be	17. Father's Name (First, Middle, Last) JULIUS	Suna Opiad		BERMAN		18. Mother's Nar			ZALKIN
Heal am 2 thar		19a. Informant's Name/Relationship (7 KARL ROSE / NEP) 20a. Method of Disposition	•	9427 20b. Place of Disp	7 FOX	HOLL	OW DRIVE		MAC, MD	n, State, Zip Code) 20864 20854 - City or Town, State
Department of I Important: If it, any injury or o		1 XBurial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	9	HEBREW Y	ematory or ot	EN C	EM.06/01	1/2005	WOO	DLAWN, MD ROS., INC.
Medical Medical the purial-transit	dical Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last	a	a consequence of): EMENTI a consequence of): EMENTI a consequence of):						Interval Betwe Onset and Dea
by the attending phatached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 1	2 Fetal death 3	□Ectopic pre □ Other (spe					ate of delivery onth Day Yea
been signed by should be deta	by	Part II. Other significant conditions co	entributing to death bu	it not resulting in the t	underlying ca	use give	n in Part I.		tobacco use con	itribute to the cause of deat
ate has page 2	Completed							24a. Was auto perfo	psy ormed?	Were autopsy findings ava prior to completion of caus death? 1 ☐ Yes 2 ☐ ※o
certific rector,	Be	25. Was case referred to medical examiner?	Hospital: 🛶				26. Place of Dea			
ath. rr: After this se funeral di	atlon: To	1 Yes 25 No 27. Manner of Death 1 SNatural 5 Pending 2 Accident investigation	28a. D te of Injur (Month, Day	y 28b. Time o		lc. Injury Work	at Nuising H		dence 6 Oth	
24 hours after death. 9 Fun aral Diractor: Af etely filled in by the fur	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc.	ry - At home, farm, st . (Specify)	treet, factory,	office		28f. Location (. City or To	Street and Numi wn, State)	ber or Rural Route Number
within 24 hours affe To the Funaral Dir completely filled in	ledical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best o iner: On the basis of and manner stat	examination and/or in	th occurred anvestigation, i	t the time in my opi	e, date and place inion, death occu	, and due to the rred at the time,	cause(s) and made and place,	anner as stated. and due to the cause(s)
	Σ	29b. Signature and title of certiler		1.D	29c.	License	number		29d. Date signe	d (Manth Day Varia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 1148 AM -AVERA MOSBY IDA 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 40spita NA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12 - 11 - 1949 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2**⊠** F 24.50.2405 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Modical Examinating by notified at 1 No Yes 2 No Director MD NA BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? AVE. 2152 or Items 23a W. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: BLACK 3 ☑-Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done di life. DO NOT use retired) (Specify only highest grade completed) during most of working 12 should be filed within I hand Mental Hygiene. 7 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) - YRS MAINTENANCE. 12 TH GRADE MECHANIC CITY BALTIMORE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JOHN MOSBY ADA MAKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trait SON 2152 W. PATHPSCO BALTO. MD ERIC FLOYD AVE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State GREENMOUNT ¹ 4 □ Donation 5 □ Other (Specify) 06.02.05 BALTO. MO 21. Signature of Funeral Service Licensee VAUGHN CADO GREENE FUNERAL SERVICE Van 5151 BALTO. NATU PIKE BAUTO. MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or help t failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a con equence of): Priysician /Medical Examiner Metastatic breast Concer Sequentially list conditions, i.a.y, Jacong John Sciente cause. Enter Underlying Cause (Disease or injury Examiner certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached for 9 Unknown 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Janets Mellitis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Vaxuelor Accident this certificate has autopsy performed? 1 ☐ Yes ~2 1 No 25. Was case referred to medical 1 ☐ Yes 2 No filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 20ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 21 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After or Attending 5 Pending Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) durathann, M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 (aton Eddna

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

JUN 0 2 2005

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1 tem 17 per fn 8844 6-2-05 vt. State of Maryland 7 Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Henry Mims 7:20 P M May 31 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Forest Haven Nursing Home Catonsville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 12M 20F Hours 184-03-048 89 Director Yrs. 1915 Carolina 15 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other traumatic event, the Medical Examiner must be notified at Catonsville 1 ☐ Yes 2 ☐ No Completed by Funeral Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 701 Ave. alaab Items 23e Edmondson USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) lath Mechanic Auto Eather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be n and Mental h Hattie Hildebrand Wayman Mima 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 6401 Deer Park Rd. Reisterstown, mo Darrell Mims - Son 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of h Important: If ite any injury or of once. 6-3-05 Other (Specify) METRO CREMATORY ame and Address of Facility Y. M. MARCH FUNERAL HOME P.D. FREDHILTON PASS BALTO MD 21229 neral Sarvice Licens 23a. Part / Enerth disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or reart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Sause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 10 Unknown filled in by the funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2ДNo 1 ☐ Yes ∕2 ☐ No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2/100 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To 1 Tyes Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 333 37 MAY 2001 un 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mn, 5400 OLD Court KOAD, MOZII33 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUN 02

DHMH 17 Rev 1/2001

Registrar

NILLIAM

JUN 0 2 2005 King It forth

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Andrew S. Meros /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner County of Dea BURNIE NORTH-ARUNDER GLEN If Under 24 Hrs. 6. Sex 1 M 2 ☐ F If Under 1 Year **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) Days Hours 165 18 3504 Yrs Director Pennsylvania Ĩ913 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location or 28a-f ehow 10d. Inside City Limits other traumatic avent, the Medical Examinar must be notified at Director Marvland Montgomery Potomac 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itams 23a 12211 Devilwood Drive U.S. 20854 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No þ 3 →Widowed 4 □ Divorced natural', Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ont: If item 27 is marked other then " College (1-4or 5+) Elementary/Secondary (0-12) Ship Fitter Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anthony Meros Veronica Czachor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Meros / Brother 12211 Devilwood Drive Department of Health Importent: If item 27 Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Glen Haven Mem. Park 5/31/2005 Glen Burnie, Maryland injury ^¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses 4001 Ritchie Highway Baltimore, Maryland 21225 manuay 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PERITOUTIES Immediate Cause (Final **Physician** disease or condition resulting in death) DAY /Medical Due to (or as a consequence of): Examiner JEJUNOSTOMY TUBE PLACEMENT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) to the Hospital or Attending Physician: The law requires that the daath certificate be executed Due to (or as a consequence of): the burial-Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 2 3 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of prior to completion death? perform 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient Certification: To 1 🗌 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a To tha Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 0060796 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAN NORTH 6 LISN ARUNDIEL HOSPITAL 31. Date filed (Month, Day, Year) 2 32. Egistrar's Signature 2005 Registrar

MEROS, ANDREW

			1 - For State Registrar	State of Ma	aryland		artment of H		Mental Hygi	ene	San San San San San San San San San San	8482
	Physici		1. Decedent's Name (First, Middle, Las	Mary Lou	ise M	lurry			2. Date of Death Month	. Day	Year 005	3. Time of Death
	/Medi Examir		4a. Fecility Name (If not institution, give	street and number) ES HEA	LTH	CARE	BAL	Location of Death	_	4c. County		U231 "
	Funeral Director		219 30 9730	7. Ag	e (In yrs. Ia 71	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan. 6,	1934	9. Birthpl Count Mary	ace (State or Foreign try) Land
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	cation				10	Od. Inside City Limits
	he Mar 8a-f sl	Director	Maryland N/A			Baltin	1					1 AYes 2 No
	death with the Maryland ms 23a or 28a-f show rmust be rediffed at	ii Dir	10e. Street and Number 1964 Sponson S	treet			10f. Zip Code 212	230	10	g. Citizen of N		ry?
	r death	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	i. 13. V		ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-	14. Rac	e - America	
9036	ours afte	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🕱 № If Yes, Give Year or Dates:	No		☐ Yes 2 No	Specify:	, , , , , ,	i .	√ Whit	
15-0	in 72 h "natu Palice	Completed	15. Decedent's Edi (Specify only highest grad	de completed)		16a. Deced	ent's Usual Occupa and of work done of	ation furing most of work)	ring 16	6b. Kind of B	usiness/Ind	ustry
212	ed withi	Somp	Elementary/Secondary (0-12) 6th	College (1-4or 5	5+)		maker	,		Own	Home	
Maryland 21215-0036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Madical Examiner must be retified at once.	To Be (17. Father's Name (First, Middle, Last) Georg	e Griffo					e (First, Middle, Ma rgaret Ra		re)	
Mar	id 2 shoth and the and the shoth should be sho		Mary Dugger / Da	_{урв, Print)} ughter			Address (Street a		al Route Number, (
ore,	es 1 an of Heal fitem 2 r other		20a. Method of Disposition		20b. Pla		ition (Name of atory or other place			ore, r		and 21230 vn, State
Baltimore,	t. Page tment tant: ti tjury o		1 \(\frac{1}{N} \) Burial 2 \(\subseteq \) Cremation 3 \(\supseteq \) 4 \(\subseteq \) Donation 5 \(\supseteq \) Other (Specify)		1	timore	Nationa	$1 - \frac{6}{2}$				aryland
Bal	Depar Depar Impor any ir		21. Singler of Funeral Service Licens	99	. Ale				once Fune			, P.A. and 21225
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused ne cause on each lir	the death.	Do not ente	r the mode of dying	, such as cardiac	or respiratory arres	t,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a ART	ERI	OSC	LEROTI	ic VASC	WAR L	DISEA		Onset and Death
	Examiner		Conventially list and divisor	Due to (or as a	a conseque	ence of):						
	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a conseque	ence of):						
ó	cate be executed physician and the burial-transit		that initiated events resulting in death) Last	Due to (or as a	a conseque	ence of):						
/ 38760,	icate be physici s the bu	dical		d								
O. Box	that the death certific ed by the attending p detached for use as	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 14 Pregnant at 19 Unknown	2 Fetal d	leath 3□E	Ectopic pregnancy Other <i>(specify)</i>			23d. Date Mor	e of delivery	y Day Year
U. /	res that the d signed by the be detached	by P	Part II. Other significant conditions con	atributing to death bu	ıt not result	ing in the und	derlying cause give	n in Part I.		_		cause of death?
	The law requires te has been sign age 2 should be	ompieted							1 ∐ Yes 24a. Was an		3 Probai	
/ al Re	10 TT	Comp							autopsy performe	d? d	rior to comp eath?	sy findings available pletion of cause of
N N	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ▼ No	lospital:	nt 2154 E	R/Outpatient		26. Place of Death	n <i>(Check only one)</i> me 5 🗌 Residenc	0.504		200
T uot	ding Phys h. After this funeral di		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injun (Month, Day		8b. Time of Injury	28c. injury Work	at 2	28d. Describe how			
isio	death.	licati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju		a form stra	M 1 🗆 Y	es 2 No	39f Location (Street	40 - d M 1-		
5 5	tal or A s after al Dire	Certification:	4 Homicide determined	building, etc.	. (Specify)	, iaiii, siiee	it, lactory, office		28f. Location (Stree City or Town, S	itate)	r or Hurai F	10ute Number,
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral.	edical	29a. Certifier (Check only one) i Certifying Physical Examination (Check only one)	sician: To the best o ner: On the basis of and manner stat	examination	edge, death on and/or inve	occurred at the time stigation, in my opi	a, date and place, a nion, death occurre	and due to the caus ed at the time, date	e(s) and mar and place, a	nner as stat nd due to th	ed. ne cause(s)
	To ti Vithi To ti com		29b. Signature and title of certifier)		α	29c. License			Date signed		
	7	-	30. Narhe and address of person who co	emplement cause of do	MI	39) (Tuno B	1000	15384	19 N	AY à	18,2	005
	٧		SCOTT BERGE	SON M.	D. S	ST. AC	NES HE	EHLTHCA	RE 900	O CHI	ONA	005 BALTO AVE DIARYAN
-	Sta Registra		31. Date filed (Month, Day, Year) JUN 0 2 200	2. Registra	r's Signatur	" April	W					

ell Powel	LΙ	State of Maryland / Department of Heat 1- State Unpend Item 23a&27 per me G845-2 milicals of the State of the	alth and M	ental Hygie	71115	181.8
Physici /Medic Examin	cal	Decedent's Name (First, Middle, Last) CORDELL LANGSTON POWELL 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Local Control		2. Date of Death Month	Day Year 28, 2005 4c. County of Deat	
Funeral Director			nie f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	Anne Ar	rundel hplace (State or Foreign untry) MD
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 la marked other than "natural", or Itams 23a or 28a-f ahow any injury or other traumatic avant. The Medical Example investor indiffed at once.	leted by Funeral Director	10a. State 10b. County 10c. City, Town or Location MD ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 222 FOXTREE DRIVE 21C6 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 See Specify Cuban, No. 1 See Specify C	Specify:	cify Yes or No- Rican, etc.)	Citizen of What Con USA 14. Race - Ameri Black, White Specify: B) Kind of Business/I	ncan Indian, a, etc.
Mal yiallo ZiZi d 2 should be filed within th and Mental Hygiene. 27 la markad other than traumatic avant, the Me	To Be Completed	3 RO GRADE NA STUDENT 17. Father's Name (First, Middle, Last) MELVIN POWELL COMESSION OF THE STUDENT 18.	3. Mother's Name	(First, Middle, Maid		
permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is no any injury or other traunone.		19a. Informant's Name/Relationship (Type, Print) CAROL HARMON MOTHER 22 FOXTREE D 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of VAUGHN C. GRE 5 151 BALTO NA	DRIVE DO	GLEN BU 200. -05 GU NERAL SER	URNIE MI Location - City or T EN BURN NICE	D 21061 Town, State
Physician /Medical Examiner	ler	23a. Part 1. Ent. / the disease, or complications that caused the death. Do not enter the mode of dying, su shock, or heart ailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Complications of Cerebral Parallel Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
ate be hysicia	ın/Medicai Examine	C. Due to (or as a consequence of): d. IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliv	rery
es that the deatl	by Physician/Med	in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 1 ☐ Live birth 2 ☐ Fetal death 5 ☐ Other (specify)	n Part I.	23e. Did tobacco	Month	Day Year the cause of death?
The law requir ate has been s page 2 should	e Completed to			1 Yes 24a. Was an autopsy performed? 1 Yes 2 N	24b. Were auto	bably 4 Unknown opsy findings available ompletion of cause of 2 No
Phys this aldi	Certification: To Be	1 Yes 2 No	2 No	e 5 ☐ Residence 3d. Describe how inj	ury occurred	
Hospita 4 hours Funaral ely fillec	edical Certifi	28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, de and manner stated.	tate and place, an	If. Location (Street and City or Town, State of the cause) If due to the cause (and the time, date and the t	(e)	totad
To the within 2 To the Complete	W	29b. Signature and title of certifier OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			May 29,	2005
Stat Registra	_	ANA RUBIO, M. 111 Penn 31. Date filed (Month, Day, Year) JUN 0 2 2005 Line & Spack	street	Baltimore	e, Maryla	nd 21201

			State of Ma		artment of Health and M rtificate of Death	lental Hygier	GUU:	18484
	Physici	an	Decedent's Name (First, Middle, Last) Melvin John	Pumph	rey Sr.	2. Date of Death Month May 26	2005 Year	3. Time of Death 6:15 P M
y	/Medic Examin		4a. Facility Name (If not institution, give street and number)	1 umpir	4b. City, Town, or Location of Death		4c. County of Deat	
	LXaiiiii	C)	1051 Sixth Street		Glen Burnie		Anne Arı	unde1
	Funeral Director		218-18-7669 XX ^M ^{2□} F	(In yrs. last birthday) 80 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Sep 16,1	9. Birti 924 MD	hplace (State or Foreign untry)
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	Aary a-f sh	tor	MD Anne Arundel	Glen Bur	nie			1 Yes 2 No
	or 28	Direc	10e. Street and Number		10f. Zip Code		Citizen of What Co	untry?
	eath v	Funeral Director	1053 Sixth Street 11. Marital Status 12. Was Decedent 8	ver in U.S. 13	21060 Was Decedent of Hispanic Origin? (Sp.		U.S.A.	rican Indian.
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic evant. The Midical Examiner rutal be notified at once.	þ	Amed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced Year or Dates:	0	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes XXNo Specify:	Rican, etc.)	Black, White	
21215-0036	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16b.	Kind of Business/	Industry
121	within ane. than "	mpl	Elementary/Secondary (0-12) College (1-4or 5	+)	DO NOT use retired) t Metal Worker		U.S Coast	Cuard
2	filed y Hygie other i	e Co	4 17. Father's Name (First, Middle, Last)	Shee		e (First, Middle, Maid		Guard
/lan	uld ba Mental rrked o	To Be	Edward Leach		Margaret	Barbara :	Krause	
Maryland	d 2 sho h and l 7 Is ma traume		19a. Informant's Name/Relationship (Type, Print) Mrs. Debra Klemm / daughte		ng Address (Street and Number or Rura Sixth Street, Gle			
ē,	s 1 and f Healt item 2 other		20a. Method of Disposition	20b. Place of Dispo		_	Location - City or	
altimore,	Page nent o ant: If ury or		1 XBurial 2 □ Cremation 3 □ Removal from State 1 Donation 5 □ Other (Specify)	1	en Mem. Park May 3	0,2005 G1	en Burnie	e, MD
Balt	permit. Departr Importa any inji		21. Sign used in heral Service Licensus Malure Deux		Name and Address of Facility Sir Second Avenue S.W	_		
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir	the death. Do not ent e.	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		ICER			2 MONTHS
	Examiner		Due to (or as	a consequence of):				
7	n =	ner	Sequentially list conditions, if any, leading to animothetic cause. Enter Underlying Cause (Disease or injury	s eonsequence of):				
V	acute and -trans	Examiner	that initiated events c.	a consequence of):				
8760,	death certificate be exacuted e attending physician and od for usa as the burial-transit		d					
9	eath certifica attending ph i for usa as th	/Medi	IF FEMALE: 23c. If yes, outcome	of pragnancy				-
.O. Box	that the death one that the detached for use	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2 Fetal death 3	□Ectopic prøgnancy □ Other (specify)		23d. Date of deli Month	Day Year
Δ.	law requires that the as bean signed by th 2 should be detache		Part II. Other significant conditions contributing to death be	it not resulting in the u	· · · · · · · · · · · · · · · · · · ·	23e. Did tobacc	o use contribute to	the cause of death?
Division of Vital Records,	e law req has bear je 2 shou	Completed by				24a. Was an autopsy performed	prior to d	topsy findings available completion of cause of
la	ician: The certificate hi rector, page	e Co	25. Was case referred to medical		26. Place of Death	1 Yes 2	√o 1 □ Yes	2 No
<u></u>	Physician: r this certific ral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatie	nt 2 ER/Outpatier	Othor	me 5 Residence	6 XOther (Spec	
n o	ding Pt h. After th funeral		27. Manner of Peath 28a. Date of Injur 1 ⊟Natural 5 □ Pending (Month, Day	Year) 28b. Time o	Work?	28d. Describe how in	jury occurred	house
Sio	l or Attending after death. Director: Afte I in by the fune	ficati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury	ry - At home, farm, str	M 1 ☐ Yes 2 ☐ No	28f. Location (Street	and Number or Ru	ral Route Number,
<u>≥</u>	al or A s after il Direction by	Certification:	4 Homicide determined building, etc	. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Town, St	ate)	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of and manner sta	examination and/or in	h occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as ind place, and due	stated. to the cause(s)
	To the To the Comp	Ň	29b. Signature and title (Comitier		29c. License number		Date signed (Month	
	n		· Could pf ff of s.		125807	3	131105	-
	3		30. Name and address of person who completed cause of d. CARLOS & 21667 M. (eath (Item 23a) (Type,		N HWY	GLEN B	CURNIE MS
	Sta	te	31. Date filed (Month, Day, Year) 32. Registra	r's Signature			~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	- 0/
	Registr	ar	JUN 0 2 2005	w K A	asset .			

Patient known as Robinson Richard

DHMH 17 Rev 1/2001

amend item#20b, perFH, G844, 6/9/05 TI For Amend Items 23a, Pt1, Pt11, per Dr., C643, 07/25/05dhb
Registrar
Reg. No. 18485 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) May **Physician** 7:38 AM 27 Kobinson 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Sinai Hospital of Baltimore Baltimore City If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Onth Cart Gran 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Maryland 15-52-46 100 M 2□ F 54 Yrs. Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f show the Medical Exemplar must be notified at 1 XYes 2 No **Funeral Directo** Mary and 10e. Street and Number more 10g. Citizen of What Country? 10f. Zip Code 21 22 USA ondson death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Bla þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene, other than " Elementary/Secondary (0-12) College (1-4or 5+) eldei 0 nt of Health and Mental Hygis if item 27 is marked other or other traumatic evant. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be chara Kobinson ITAMI:N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Hural Route Number, City or Town, State, Zip Code) Mar Department of Health ar importent: if item 27 is eny injury or other trac Ave. Balto, Md. 21223 2415 Kobinson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition-1 Burial 2 Cremation 3 Removal from State tento 6/8/2005 mode Balto. `4 □ Donation 5 □ Other (Specify) Mount Zion 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Home, 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 24 hours Immediate Cause (Final disease or condition resulting in death) Sepsis Gram pos. cocci **Physician** /Medical Due to (or as a consequence of): Examiner Gastrointestinal Bleed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Liver Failure that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Hepatitis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? 1 ☐ Yes 2,**Z**-No or Attanding Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attanding Physical within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directors. 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28b Time of Certification: 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Maccident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number May 27, 2005 RES-000 Kr 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO. Sinai Hospital of Baltimore KREUTZ N 02 32. Distrar's Signature 31. Date filed (Month State Registrar

ORIGINAL

1:14 a.m.

. Jes or . This in Didok illdeli	DIC IIIK.	Liisuie Ali	Cobies Wie F
State of Maryland / Departm	nent of He	ealth and Me	ental Hygiene
0			

			1 - For State Registrar	State of Maryla		artment of F rtificate of			giene Reg. No. 2	2	1010
	Physic /Med		1. Decedent's Name (First, Middle, La: Helen Stephanie Roch	e				June 1, 2	Day	Year	3. Time of Death C
1	Exami	ner	4a. Facility Name (If not institution, give Stella Maris			4b. City, Town, o Timoni	um		4c. County of Baltim		
	Funeral Director		5. Social Security Number 6. S 212-28-9579 1 Usual Residence of Decedent		s. last birthday) 96 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		26, 1908	9. Birthpi Coun Mary]	
	death with the Maryland ms 23a or 28a-f ehow fillual by Folified at	tor	10a. State 10b. County Maryland Baltim		city, Town or Lo arney	cation				10	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ath with the Marylar 23a or 28a-f ehow	ai Director	10e. Street and Number 8806 Lakewood Road			10f. Zip Code 21234			10g. Citizen of W	hat Coun	try?
920	ours after dea rai', or Items Erani or Item	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Widowoced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates:	1	Vas Decedent of H i Yes, specify Cuba	ispanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)		- America , White, e	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after des Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or Items any injury or other treumetic event, the Medical Examinet III once.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)		ent's Usual Occupa kind of work done of DO NOT use retired hone Operat		vorking	16b. Kind of Bus		•
yland ;	ould be filed Mental Hyg arked othe etic event,	To Be C	17. Father's Name (First, Middle, Last) Charles Hanzlik		тетер			ame (First, Middle,			
	and 2 sho alth and 127 is m er treum		19a. Informant's Name/Relationship (7 Lucille R. Boellner/Dat					Rural Route Numbery, Maryland		state, Zip	Code)
Baltimore,	Pages 1 ament of He ent: if item		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Removal from State Dul	Place of Dispos cemetery, crem aney Val			Date /6/05	20c. Location - C	•	
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licens	X Witton	53	Name and Addres opard J. Ru 05 Harford	Road Ba	Itimore Mary	/land 212	14	
68760, 李	Physician and by Scient and by Scient and see the burial-transit as the burial-transit	sal Examiner	23a. Part1. Enter the disease, or compositions, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying that initiated events resulting in death) Last	a. DEMENTIA Due to (or as a consect.) Due to (or as a consect.) Due to (or as a consect.)	quence of):	ir the mode or dying	, such as cardi	ac or respiratory ar	rest.		Approximate Interval Between Onset and Death
.O. Box	The law requires that the death certificat tie has been signed by the attending phy age 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregn 1	al death 3 □I	Ectopic pregnancy Other (specify)			23d. Date Month		/ Day Year
rds, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions co	ntributing to death but not res	sulting in the un	derlying cause give	n in Part I.		bacco use contrib		cause of death?
al Records,		Completed						24a. Was a autops perform	ned? dea	ere autops or to comp ath? Yes 2	sy findings available bletion of cause of
Vital	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	fospital:	ER/Outpatient	3□ DOA Othe		eath (Check only on	110		
n of	ding Phy h. After thi funeral o		27. Manner of Death 1 XNatural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at	Home 5 Reside	ow injury occurred		
=	ten feat for: the	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, stree	M 1 □ Y	es 2□No	28f. Location (St City or Town	reet and Number n, State)	or Rural F	Route Number,
	d hours t hours unerel	edical Ce	29a. Certifier (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death ation and/or inve	occurred at the time estigation, in my opi	o, date and plac nion, death occ	e, and due to the caurred at the time, do	ause(s) and mann ate and place, and	er as stat	ed. ne cause(s)
•	To the within 24 To the Complete	Me	29b. Signature and title of certifier	2		29c. License	number	7	9d. Date signed (I	Month, Da	iy, Year)
	2		30. Name and address of person who co						/:/		
	Sta Registr		31. Date filed (Month, Day, Year)	D 2300 DULAN 32 Registrar's Signa	EI VALL	EY KD.	LIMONIU	MD 210	93		

			State of	or Maryland / Dep Ce	ertificate of		, ,	jiene _{leg. No.} 2 N N	5 191.97
	Physic	ian	1. Decedent's Name (First, Middle, Last)				2. Dete of Dee Month	Sup last 1 2 7	3. Time of Death
and a	, /Medi	cal	CHARLOTTE E. RAY				05.25	2005	5:40 PM
1	Exami	ner o	4a Fecility Neme (If not institution, give street and nu JUUA MANOR NURSIN	_		4b. City, Town, or L		4c. County of De	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. lest birthday	() If Under 1 Year	AGERSTO If Under 24 Hrs.	8. Date of Birth (Month, Dey	WASHIN	irthplace (State or Foreign Country)
	Director		220.12.4979 10M 285 F	82 Yrs.	Months Deys	Hours Min.	(Month, Dey	(Year)	MD
	and	٦	Usuel Residence of Decedent 10a. Stete 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
	Marylar f show	ţō	MD WASHINGTON	HAGERST					1 ☐ Yes 2 🖪 No
	ith the M or 28a-f	irec	10e. Street and Number	TW COLKE	10f. Zip Code		1	0g. Citizen of What (Country?
	23a c	Funeral Director	116 W. BETHEL STREE	T	217	40		USA	
	er de	nue	11. Marital Status 12. Was Deco	edent Ever in U,S. 13.	. Was Decedent of H If Yes, specify Cube	lispenic Origin? (Sp en, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indien, nite, etc.
020	hours after death with the Maryland ural; or flems 23a or 28a-f show al Examinan must be notified at	by F	1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes If Yes, Girl Year or D	2 M No /e ates:	1 ☐ Yes 2 1 No	Specify:		Specify: 12	1 A C IV
21215-0020	72 hours "natural", adical Ex	ted	15. Decedent's Education	16a. Dec	edent's Usuel Occup	etion		16b. Kind of Busines	s/Industry
121		npie	(Specify only highest grade completed) Elementery/Secondary (0-12) College,(-4or 5+) 175-0	e kind of work done of DO NOT use retired	d) most of work		000-66	
	Hygier Hygier Ther th	Col	12 TH GRADE N 17 17. Father's Neme (First, Middle, Last)	1 BEH	UTICIAN	18. Mother's Name		COSMETO	10G1ST
Maryland	parmit. Peges 1 and 2 should be filed within Department of Health and Mantal Hygiene. Important: If Itam 27 is marked other than any injury or other traumetic event, the Manging.	To Be Completed	JOHN MORRIS			RACHEL	DAVEN	,	
ary	2 shou and N is mar	_	19a. Informant's Name/Relationship (Type, Print)	1	ling Address (Street			, City or Town, State	, Zip Code)
	and 3 lealth m 27 i		SANDRA HUDSON (DAUG		W. BETHE	L ST., HI	AGER810	am, uw	21740
Baltimore,	parmit. Peges 1 and Department of Health Important: If itam 27 any injury or other to once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from	State	ematory or other place			20c. Location - City of	or Town, State
Ē	artmer ortant injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Functal Service Liceus a	ARBUTUS		cs of English	6.01·05	ВАЦТО. 1	MD
B	parmit. Departr Importa any inju		2) anon (II		2. Name and Addres				
			23a. Part1. Enter the disease, or complications that c shock, or hand failure. List only one cause on e	aused the death. Do not er	151 BAUD. Noter the mode of dyin	g, such as cardiac	BALTO, I	mo 21229	Approximate Interval Between
	Physician		Shock, or reservatione. List only one cause on e	ach line.					Interval Between Onset and Death
	/Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)	10-105 clys	Mc Cax	diovesco	lor of	Reme	1.X
		- Le	/	Due to (or as a conse		7 1			
	cuted	Examiner	Sequentially list conditions	Due to (or as e conse	guence of):	(74			787
Ő,	e exe ian ar urial-t		Sequentially list conditions, if any, leading to immediate cause. Enfer Underlying Ceuse (Disease or injury c		1,50,000				
68760,	icate be executed physician and s the burial-transit	edicai	that initieted events resulting in death) Last	Due to (or as a conse	quence of):				
Box 6	± 00 €	√Me	d			///			
œ.	daath e attar ed for e	iciai	Part II. Other significant conditions contributing to de	ath but not resulting in the u	Inderlying cause give	en in Part I	23h Did to	hacco uso contribut	te to the cause of death?
P.O.	v requiras thet the daath cer been signed by the attandin should be detached for usa	Physician/M			and onlying decision give	on arr divi.	1 □ Ye	1/	Probably 4 Unknown
S,	ras th signed	þ							
Records,	been should	Completed					24a. Was ar perform		. Were autopsy findings available prior to completion of cause
Rec	a has	dmo					CONTRACTOR	V	of death?
Vital		Beco	25. Was case referred to medical			26. Place of Death	Chock only on		1 ☐ Yes 2 ☐ No
*	S S	일	examiner? 1 Yes 2 No Hospital: 1 I	npatient 2 ER/Outpatie	nt 3 DOA Othe			nce 6 □Other (Sp	ecify)
2	ng Ph ifter th uneral		27. Menner of Death 28a. Date of (Month)	f Injury 28b. Time of Injury	of 28c. Injury Work	at		w injury occurred	
Division	Attending in death. Sector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	of Injury At home form at		Yes 2 □ No	006 1 (04		
Θ	aftar aftar Direction	Certification:	4 Homicide determined 289. Flece building	of Injury - At home, farm, st g, etc. (Specify)	reet, factory, office		City or Town	eet and Number or F , Stete)	nurer Houte Number,
	lospita I hours uneral	edicai (29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Medical Examiner: On the bar	pest of my knowledge, deat	h occurred at the tim	e, date and place, a	and due to the ca	use(s) and manner a	s stated.
	To the Hospital or Attending Pr within 24 hours aftar death. To the Funeral Director: After it completely filled in by the funeral	Med.	one) and mann	er stated.	29c. License				
	¥ <u>₹</u> ₹ 8		Son organization and title of continol			-		d. Date signed (Mon	nn, Day, 1881)
	1/		Q. Name end eddress of person who completed gauss	1 death (Item 23e) (Type	Print)	(533.	2	7 00/.	
_	v)		John Charles Ce	Joksey	n	10nro	e Xa	- 7/2	01
	Stat		11. Date filed (Month, Day, Year) 2. Re	gistrar's Signature			1		

WCII ICWI	.S K	1 - State Amend Item 3 Registrar		6-9-05 _{e1}	tificate of l	Death		Reg. N	2005	LRUR
	ician dical		uis Root J	r.			2. Date of D Month May	Da	ay Year 2005	3. Time of Death 10:11 10:05 A
	niner	4a. Facility Name (If not institution, give North Avenue & Hor 5. Social Security Number 6. Se	mberg Street	s. last birthday)	4b. City, Town, or ESSEX If Under 1 Year	Location of Death		В	altimore	
Funer Direct			M 2□F 25	**	Months Days	Hours Min.	8. Date of B (Month, D Apri	ay, Year	Cou	place (State or Foreigi intry) aryland
Maryland -f show	tor	10a. State 10b. County MD Baltim		City, Town or Lo	Essex					10d. Inside City Limits
ith with the Marylan 23a or 28a-f show	i Director	10e. Street and Number 240 Orville Ro	ad		10f. Zip Code 2122	1		10g. Ci	itizen of What Cou	intry?
er des	by Funeral	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give	H	Vas Decedent of Hi	ispanic Origin? (Spanic Origin? (Spanic Origin), Mexican, Puerto	ecify Yes or N Rican, etc.)		14. Race - Ameri Black, White,	
Maryland 21215-0036 the 2 should be filed within 72 hours aff and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exercitations.	Completed	15. Decedent's Edu (Specify only highest grade	Year or Dates: cation e completed) College (1-4or 5+)	16a. Deced (Give	ent's Usual Occupa kind of work done of ONOT use retired	ation during most of worki)	ing		Kind of Business/Ir	ndustry
ore, Maryland 21215-C is 1 and 2 should be filed within 72 h of Health and Mental Hygiene. Item 271s marked other than "natu other traumatic event, the Medical	Be	12th 17. Father's Name (First, Middle, Last)		Dani	cacion	18. Mother's Name	e (First, Middle	e, Maider	Sumame)	
Caryla 2 should and Men is marke aumatic	2	Lowell L. Roo	pe, Print)	19b. Mailin	g Address (Street a	Patric and Number or Rura				o Code)
Te, 1 ar Hea		Lowell L.Roots 20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	20b.	Place of Dispos	O Vailth ition (Name of atory or other place of Faith	norn Roa	Date	20c. L	ore MD ocation - City or To	•
Baltimo	SUCE.	21. Signature of Funeral Service License	-		Name and Addres	/ P . 105	nnelly	Fun	eralHon	neofEssex
Physicia /Medica Examine	al,	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated eyents	Due to for as a consu	equence of):	ir the mode of dying	g, such as cardiac c	r respiratory a	arrest,		Approximate Interval Between Onset and Death
ecords, P.O. Box 68760, law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	edical	IF FEMALE: 23b. Was decedent pregnant	Due to (or as a conse	nancy					23d. Date of delive	eny
IS, P.O. Bries that the deat signed by the att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5	Ectopic pregnancy Other (specify)				Month	Day Year
cords, I w requires thi been signed	by	Part II. Other significant conditions con	tributing to death but not re	sulting in the un	derlying cause give	n in Part I.	23e. Did 1			ne cause of death? nably 4 □Unknown
Vital Rec sician: The law of certificate has be	e Completed	25. Was case referred to medical				00 Plan (Paul	1/2 Yes	psy ormed? 2 \(\text{No}	prior to con death?	psy findings available mpletion of cause of 2 No
Oivision of or Attending Physiter death. Director: After this in by the funeral di	edical Certification; To B	27. Manner of Death 1 Natural Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifying Phys	28a. Date of Injury (Month, 2 y Year) 28a Place if Injury - At i building, etc. (Specialist To the best of my kner; On the basis of examinated many read ma	28b. Time of Injury Shome, farm, streetify)	Other 28c. Injury Wark M 1 ot, factory, office	es 2 No 2	18d. Describe 18f. Location (City or To	dence how injur Street an wn, Sate	d Number or Rura	Test trud I Route Number,
To the Hospital within 24 hours a To the Funeral completely filled	Medi	29b. Sign vura and tyle of certifier	u)		29c. License OCM	number			e signed (Month, 1	Day, Year)
15		30. Name and address of person who see	neleted cause of death (Ite		III Penr	n Street			, Marylar	
S Regis	tate trar	31. Date filed (Month, Day, Year) JUN 0 2 200	3// Registrar's Sign	Ature Appe						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** May 27, Ruth Locke Roettinger 2005 7:30 R /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montogmery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, NOV 1, **Funeral** 9. Birthplace (State or Foreign Days 1 M 2 X 228 50 8190 100 Newport KY Director Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location Item 27 is marked other than "neturel", or items 23s or 28s I show other treumstic event, It e Madical Examinal must be notified at 10d. Inside City Limits Maryland 1 □ Yes 2 📉 🖔 Montomery Chevy Chase Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3305 Sheperd Street 20815 Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "neturel", or Item eny injury or other treumatic event. Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, GiveA Year or Dates: 3altimore, Maryland 21215-0036 1 ☐ Yes 2 1 to Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Dodsworth Roettinger To Bessie Bowers Herner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dick Horner (Cousin) 12904 Mount Royal Lane, Fairfax, Va 22033 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Mav 30, Lee Crematory Clinton, Maryland 2005 21. Signature of Funeral Service Lives 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 40015 Alexandria Ferry Rd, Clinton, Maryland 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ewou 11s Prysician disease or condition resulting in death) WIC /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Examiner -transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 1 Yes 2 No 5 Other (specify) P.0. the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccoruse contribute to the cause of death? Division of Vital Records, þ 1 Tyes 2 X No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 autopsy performed?/ Yes 2500 certificate 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 6. Place of Death (Check only only)
4 Nursing Home 5 Residence 6XX Other Sp. Tacility 1 Yes V No 1 Inpatient 2 ER/Outpatient Other: Medical Certification: To 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Peath 28c. Injury at Work? 28h Time of 28d. Describe how injury occurred After the Hospitel or Attending Natural 2 Accident 5 Pending after death.

Director: Aff investigation 1 Yes 2 □ No Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) 4 31. Date filed (Month, Day, Year) 32. Re trar's Signature JUN 02 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Rag. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Mary Albert Lucas Rex 29 /Medical May 2005 10:00 A 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Oak Crest Village Care Center Parkville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV • 23, 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex Birthplace (State or Foreign Country) 1 □ M 2√2 F 93 Director 431-84-7345 1911 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location itam 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic avent, the Medical Examination is the notified at 10d. Inside City Limits Maryland Baltimore Completed by Funeral Director Parkville 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8832 Walther Boulevard 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: 3 X Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Hygiene. College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) es 1 and 2 should be fill of Health and Mental H fitem 27 Is marked off Be Richard J. Lucas 0 Hildegarde (NMN) Hartmaier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary D. Deyesu/Niece 67 Crystal Court, Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State **7**0 ō © Burial 2 XCremation 3 □ Removal from State Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 6-1-05 Towson, Maryland thre of Funeral Service License 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, MD 21009 ens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) RW /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Uisease or injury that initiated events Examiner Due to (or as a consequence of). The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Day Year 4 Pregnant at time of death 5 Other (specify) P.O. ed by the a detached f 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 4 Unknown Be Completed 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2/3 No 1 Tyes tha Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No 2 Dther: ursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral of 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 2 Accident investigation 1 Yes 2 No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) a Funeral Direct 4 Thomicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m Pakull 8600 Walth 21214 ondson 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registra

JUN 0 2 2005

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Betty Melba Ritter Month Year 2005 -DOM M /Medical SV 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death unde) mile 103 San SVW If Under 24 Hrs. 5. Social Security Number 6 Sev yrs. last birthday If Under 1 Year 8. Dete of Birth (Month, Day, Year) Oct. 25, 1925 **Funeral** Birthplace (State or Foreign
Country) 1 □ M 2 K Days Min Hours 219 10 3252 Yrs **Director** Oct. Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or Items 23a or 28a-f show any injury or other treumatic event, It is Medical Examinating matter matter mentice. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Marvland Director Anne Arundel Severn 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7919 Clark Station Road U.S. 21144 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk North Arundel Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Remmey Marie Pfeiffer ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elmer Ritter / Husband 7919 Clark Station Road Severn, Maryland 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 5/31/2005 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. 22. Name and Address of Facility 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease of shock, or heart failure. Lis or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Cas Physician disease or condition resulting in death) /Medical ue t (or as a onsequence of) Examiner Sequentially list conditions, Examiner as a con cause. Enter Underlying Cause (Disease or injury that initiated events equence of) attending physician and for use as the burial-transit resulting in death) Last Due to (or as a cons uence of) Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No detached for Month Day 4☐ Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ law requires page 2 should 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No After this certificate has 24a. Was an 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No npatient 2 ER/Outpatient 3□ DOA Certification: 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division To the Hospitel or Attending Month, Day Year) 1 Natural 5 Pending within 24 hours after death. To the Funerel Director: A investigation 1 🗌 Yes 2 🗌 No 2 Accident Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OWUSU-BURY KO TE 31. Date filed (Month, Day, Year) 32 Registrar's Signature JUN 0 2 Registrar

			1 - For Stete RegistrerAMFND ITE								and M	lental Hy	giene Reg. No.	0.0	5	18492
	Physici /Medio		Decedent's Name (First, Middle MAURICE	Last)	/D 114V	131 GC			ENFE			2. Date of De Month MAY	27 27	200		3. Time of Death 12:35 A M
7	Examin		4a. Fecility Name (If not institution	-		•		4b. City, Town, or Location of Death 4c. County of Death							25	
	- <u>-</u>		JEWISH CONVALE 5. Social Security Number				last birthday)		BALTIMORE If Under 1 Year					9. Birthplace (State or Foreign Country)		
	Funeral Director		217-16-0777	6. Sex 1 🔼 M	2 F	91	Yrs.	Months Days Hours Min. 03/16/1914						MD MD		
	P.		Usual Residence of Decedent			140.00										
	death with the Maryland rms 23a or 28a-f show r trust be rediffed at	5	10a. State 10b. County	N/A			sy, Town or Lo BALTIMO								1	0d. Inside City Limits 1 Yes 2 No
	the M	by Funeral Director	10e. Street and Number	N/ A			DALTING	10f. Zip	Code				10a Citiz	en of Wha	t Coun	
	23e or	直	3100 ST. PAUL	CTDE	T ADT	#Q1/	1		218				U.S.			, .
	ns 23	era	11. Marital Status	12.	Was Deceder	nt Ever in U				spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)		4. Race - A		
9	after dea	Ē	1 Never Married 2 Marri	be	Armed Force: 1/1 Yes 2 [If Yes, Give			if Yes, spec 1 ☐ Yes :		n, Mexican Specify:	, Puerto	Hican, etc.)		Black, V Specify:		
21215-0036	72 hours after "natural", or Ite	d b	3 Widowed 4 Divorced		Year or Dates	S:										
15-	"natu	Completed	15. Decedent (Specify only highes	s Educati f grade co	on ompleted)		16a. Dece	dent's Usua kind of wor DO NOT us	rk done d	urina mosi	t of work	ing	16b. Kin	d of Busin	ess/ind	dustry
12	filed within Hygiene. other then "	m d	Elementary/Secondary (0-12)		College (1-4c	or 5+)	SAL		, , , , , , , , , , , , , , , , , , , ,				RF.	TAIL		
	Hygin other	Be C	17. Father's Name (First, Middle, I	.ast)			0.12			18. Mothe	r's Name	(First, Middle				
lan	should be filed withir or Mental Hygiene. marked other then matic event, Lie M	ToB	DAVID			ROSE	ENFELD			ROS	Ε				0	STROSKY
Maryland	. a a 2	. 0	19a. Informant's Name/Relationsh					•				I Route Numb				
	of Health of Health item 27 I		MARIE ROSENFELD	<u>/ W</u> :	IFE	205 5	Ness of Disease	aiting /Alas				. 814-E		MORE, ation - City		
Ore	ges 1 it of H if ite or otl				oval from Sta	te	cemetery, crei	natory oB	THIA ac	SRAE	L					
Ħ	it. Pa rtmen rtant: njury	1	1 ②Burial 2 □ Cremation 3 □ Removal from State 1 ② Donation 5 □ Other (Specify) MIKRO KODESH ISREAL 05/29							/2005 BALTIMORE, MD L LEVINSON & BROS., INC.						
8900 REISTERSTOWN								ROAD -	PIKE			MD 21208				
			23a. Part1. Enter the disease, or shock, or heert failure. List	complicati only one c	ions that caus ause on each	ed the deat line.	h. Do not ent	er the mod	e of dying	g, such as	cardiac (or respiratory a	rrest,		F	Approximate Interval Between Onset and Death
E	Prrysician /Medical	4	Immediate Cause (Final disease or condition resulting in death)	a			ONIC R	ENAL	FAIL	URE					37	
1	Examiner			(Due to (or a	as a conseq	onic of):	ADDIO	VACC	III A D	EATI	LIDE				
		ē	Sacuentially list conditions if any, leading to immediate cause. Enter Underlying	b. —	Due to (or a	UNK as a conseq		AKDIU	VASC	ULAR	FAIL	UKE				
	outed d ansit	Examiner	that initiated events	,		ASC	VD									
o,	eath certificate be executed attending physician and for use as the burial-transit	Exa	resulting in death) Last	J	Due to (or a	as a conseq	uence of):									
8760,	ate be hysici the bu	licai		d											-	
x 68	certifica Iding ph Ise as ti	by Physician/Med	IF FEMALE:	220	If yes, outcon	an of oregon	anov.									
Вох	death c e attend ed for us	ian	23b. Was decedent pregnant in the past 12 months?	230.	1 ☐Live birth 4 ☐ Pregnant	2 🗌 Feta	ıl death 3 □	Ectopic pro					2	3d. Date of Month	delive	Day Year
P.0.	D 0 D	ysic	1 □ Yes 2 □ No 9 □ Unknown		9□ Unknown			201101 (3)								
	requires that the een signed by th nould be detache	y Pt	Part II. Other significant condition	ns contrib	outing to death	but not res	ulting in the u	nderlying c	ause give	in in Part I.		23e. Did	obacco us	e contribu	te to th	e cause of death?
rds	quires n sign	d b										10	Yes 2□]No 3[Prob	ably 4 Onknown
Records,	e law re has bee je 2 sho	Completed										24a. Was	psy ormed?	24b. Wer	e autor	osy findings available inpletion of cause of
	n: The ficate ha r, page	e Co	25. Was case referred to medical		<u>-</u>					00 Pi	- (D 1)	1 Yes	2/2-No	1 🗆	Yes	2 No
Ξ	Physicien: r this certific ral director,	00	examiner?	Hosp	oital: 1 □ Inna	tient 2□	ER/Outpatier	nt 3 🗆 DO	A Othe	-		n <i>(Check only i</i> me 5 ☐ Resi		□Other /:	Specify	·)
So to to to to to to to to to to to to to										- P - O)	<u> </u>					
i≷i	or Attu	rtific	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ned 2	28e. Place of building,	Injury - At he etc. (Specif	ome, farm, str fy)	eet, factory	, office			28f. Location (City or To		Number o	r Rura	l Route Number,
	Hospitel	Ce	29a. Certifier 1 Certifyin	Physicia	an: To the he	et of my kno	wiedne deat	occurred.	at the tim	e date an	d place	and due to the	cause/s)	and manne	r ae et	ated
	the Hos hin 24 hc the Fun npletely	Medical	(Check only 2 Medical I			of examina		vestigation,	in my op	inion, dea		ed at the time,	date and	place, and	due to	the cause(s)
	To Teo	Σ	29b. Signature and title of certifier	-0	B	60) M.	290	. License	number	(0)	20	29d. Date	signed (M	fonth.	Day, Year)
			House		leted saves	doath /lt-	222) (Turk	Print)		- (3		3	(17	- 2005
u)		30. Name and address of person	vno comp	Cause o	Ceath (Iten	(1ype.	PIN	121	10	nin	1850	HYS	(tr		Saltimire
	Sta	te	31. Date filed (Month, Day, Year)	2005	32 Regis	strar's Signa	to do	sell)	, , , , , , , , , , , , , , , , , , ,	· 60	1140		<u> </u>	11	U	
	Registr		JUN 0 2	2005	1310	الر مريكان	17									

			State of Maryland / Department of Health and M 1- State Registrar Certificate of Death		47% -5-	
	g.		Registrar 1. Decedent's Name (First, Middle, Last)	Reg. N 2. Date of Death	- UU	3. Time of Death
	Physici /Medic		Robina E. Singleton	Acres 1	ay Year 8 05	9:15 pm
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4	c. County of Dea	th A
	Funeral	-	5. Social Security Number 6. Sex 7. Age lin yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year	9 Bir	thplace (State or Foreign
	Director		212-74-9826 10 M 201 F 98 Yrs. Months Days Hours Min.	Sept. 5, 191	36 Sou	th Carolina
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	7		10d. Inside City Limits
	a-f sh	ctor	Maryland N/A Baltimore			1 TYYes 2 □ No
	with the	Director	10e. Street and Number (10f. Zip Code	10g. C	itizen of What Co	ountry?
	ms 234	neral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - Ame	
9	or Ital	by Funeral	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 No 1 □ Yes 2 No Specify.	Hican, etc.)	Black, Whit	e, etc.
21215-0036	ilied within 72 hours after death with the Maryland Hygiene. ythar than "natural", or llams 23a or 28a-f show ant, the Medical E-arthret mat be mullisd at	ed p	15. Decedent's Education 16a. Decedent's Usual Occupation	16b.	Kind of Business	ack Industry
215	thin 72 e. an "ne	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of working life. DO NOT use retired)	ng	^	1.1
	filed with Hygiene. other ther		17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Maide	DUUD_	Home
land	ould be f Mental I arked of atic ava	To Be	Anthony Crawford Sus	anna	Harr	1
Maryland	2 sh and Is m	_	19a. Informant's Name/Relatinship (Type, Print) (19b. Mailing Address (Street and Number or Rura	I Route Number, City	or Town, State, 2	Zip Code)
	1 and 1 Health am 27 thar tr		20a. Method of Disposition 20b. Place of Disposition (Name of	lights AL	ocation - City or	Town State
nor	Pages nent of t int: If its ury or o		1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify)	2005 P	s Ha	MA
Baltimore,	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Eacility 23. Signature of Funeral Service Licensee 24. Name and Address of Eacility	Elboral	Home,	PA
<u> </u>	8818		Jeseph L. Kuss 2222 W. North Av	e. Balto	Md. Z	1216
	200		23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shork, or heart failure. List only one cause on each line. Immediate Cause (Final	r respiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death) a	9		weeks
	Examiner		Sequentially list conditions b. Chronic obstructive lung d	useaseh	sthma	years
T	ted	Examiner	if any, leading to immediate Due to (or as a consequence ot): cause. Enter Underlying Cause (Disease or injury	16		
v C	execu		that initiated events c. resulting in death) Last Due to (or as a consequence of):			
8760,	death certificate be executed e attending physicien and od for use as the burial-transit	dlcal	d			
9	eath certifica attending ph I for use as t	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy	1	23d. Date of del	iven
. Box	that the death cer ed by the attendin detached for use	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1		Month	Day Year
P.0	at the d d by the etached	Phys	9 Unknown	22a Did tabasan	usa cantributo to	the cause of death?
	es pe de		Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dum HTN			obably 4 Dunknown
COL	s been si should	olete	hypertension	24a. Was an	24b. Were at	topsy findings available
- Be	The lav ate has page 2	Completed by		autopsy performed? 1 ☐ Yes 2 🖫 N	death?	completion of cause of
Division of Vital Records,	Physiclan: this certific ral director,	Be	25. Was case referred to medical examiner? Hospital: Hospital: Description of Death Differ.	1		
o	Phys er this eral dir	n: To	27. Manger of Death 28a. Date of Injury 28b. Time of 28c. Injury at 2	ne 512 Residence 28d. Describe how inju		city)
ion	ttanding death. Stor: Afte the fun	atio	2 Accident investigation M 1 Yes 2 No			
Ĭ <u>X</u> į	l or Attu after de Directo I in by ti	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, Stat	nd Number or Ru e)	ral Route Number,
	Hospital 24 hours a Funaral (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the cause(s	and manner as	stated.
	To the Hospital or Attanding Physiclan: The I within 24 hours after death. To the Funaral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.			
	To the within 2 To the complete	2	29b. Signature and title of certifier 29c. License number D25663	29d. Da	ate signed (Month	n, Uay, Year)
•	/		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	/3	"/05	
	5	100	222 W Coldsoning Lane Beltmore, MS 2210			
	Sta Registr		31. Date filed (Month, Day, Yelar) JUN 0 2 2005 32. Figistrar's Signature			
		7	7			

			For State Registrar	State of Ma	arylan		artment of H		and Mental H	ygiene Reg. No.	005	18494
8	Physici /Medio		1. Decedent's Name (First, Middle, Las Elizabeth L. Selig	t)					2. Date of D Month May 30,		Year	3. Time of Death 9:00 P M
	Examin		4a. Facility Name (If not institution, give Heritage Harbour Healt				4b. City, Town, or Annapol		of Death		ne Arund	
Ç _{i,}	Funeral Director		210-40-4924	9x □M 2X)F 7. Ag		ast birthday) Yrs.	If Under 1 Year Months Days	If Under: Hours	24 Hrs. 8. Date of B Min. (Month, D August 2	Dev. Year)	9. Birti Co Mar	nplace (State or Foreign unity) yland
	Maryland f ahow	lor	Usual Residence of Decedent 10a. State 10b. County Maryland Queen Ann	ne's		v. Town or Lo vensvil						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	h with the	al Director	10e. Street and Number 320 Cecil Road		l		10f. Zip Code 21666			10g. Citiza	en of What Co	untry?
36	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I marked other than "natural", or Items 23e or 28s-f ahow unsite event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 Y If Yes, Give Year or Dates:		'	Vas Decedent of Hi f Yes, specify Cubai I ☐ Yes 2 🛱 No	spanic Orig n, Mexican Specify:	gin? (Specify Yes or N , Puerto Rican, etc.)		4. Race - Ame Black, White Specify: Whi	e, etc.
Baltimore, Maryland 21215-0036	ithin 72 hou ne. nan "natura Nedical E	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation		(Give life. I	tent's Usuaf Occupa kind of work done d DO NOT use retired,	lurina most	of working	1	d of Business/l	Industry
land 21	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the M	To Be Cor	12 17. Father's Name (First, Middle, Last) HOWARD HIII			Housewi [.]	re		r's Name (First, Middi na Laupy	Own le, Maiden S		
Mary	and 2 shou atth and M 27 is mar ar traumat		19a. Informant's Name/Relationship (Carole R. D'Onofrio/Da						r or Rural Route Num Sville Maryla			(ip Code)
imore,	permit. Pages 1 and 2 should Department of Health and Men Important: if Item 27 Is marke any injury or othar traumatic: 000.00.		20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify)	Mor	eland M	sition (Name of natory or other place em. Park		Date 6/3/05		ation - City or more, Mai	
Balt	permit. Departi Import any inj once.		21. Signature of Funeral Service Licen	soo Christina Khloo	L. Hi	1ton 77	eonard Jorki 305 Harford	uck, in Road	ňc. Baltimore Ma	aryland	21214	
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	7° 70 VC	es culo	er the mode of dying	g, such as	cardiac or respiratory	arrest.		Approximate Interval Between Onset and Death
×	Examiner	Examiner	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	a consequ	ence of):						
8760,	cate be executed obly sician and the burial-transit	dicai Exa	resulting in death) Last	Due to (or as	a consequ	ience of):						
O. Box 6	death certific e attending p od for use as	Physician/Mec	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)			23	3d. Date of defi Month	very Day Year
rds, P.	law requires that the de as been signed by the a 2 should be detached f		Part If. Other significant conditions of	ontributing to death b	ut not resu	ulting in the ur	nderlying cause give	en in Part I.		tobacco us		the cause of death?
I Records,	The ate h page	Completed by]/					24a. We aut per 1 Yes	opsy formed?	24b. Were au prior to death?	topsy findings available completion of cause of
Vital	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	ot 2	ER/Outpatien	t 3 DOA Othe	200	of Death (Check only			
Division of	ding Ph h. After th funeral	tion: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry	28b. Time of Injury	28c. Injury Work		28d. Describe			шу)
Divisi	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inibuilding, et			eet, factory, office			(Street and own, State)	Number or Ru	ral Route Number,
	he Hospit n 24 hours he Funera	edical	29a. Certifier (Check only one) 105 Certifying Ph	ysician: To the best liner: On the basis of and manner st	examinat	wledge, death ion and/or inv	occurred at the tim restigation, in my op	e, date and pinion, deat	d place, and due to the	e cause(s) a e, date and p	and manner as place, and due	stated. to the cause(s)
•	To t Within To ti	W	29b. Signature and title of certifier	MD			29c. License		3	29d. Date 5 / 3	signed (Month	n, Dey, Year)
	'n		30. Name and address of person who of Control	completed cause of d	10	02 /2	ALL HILL	hary	, S. W.	Glin	Byrni	e 21061
	Sta Registi		JUN 0 2	2005	19.	ture	berte					
DH	MH 17 Rev 1/2	001		100								

ORIGINAL

Physician Medical Examiner County State				1 - For State Registrar	State o	f Marylan			nt of He te of D		Mental Hy ا	giene Reg. No. 🗥	frie F. som	. ====
Second Second Control Second Second Second Control Second Second Second Control Second S	ı			1. Decedent's Name (First, Middle, La		Alvi	n Sc	hult	neis,	Sr.	2. Date of Dea Month	ath Day		
State Search Was also as a Foundable Purposed Direct Provided Prov	*			4a. Facility Name (If not institution, give	e street and nu	mber)		4b. City	, Town, or	Location of Death				1.00 1
The control of the co				812 Jeannette A	venue				Dund	a1k		В	altimo	re
The company of the		_					•				(Month, Da		Coun	itry)
Prederick Schultheis Leana Newman State Companies State						05					Juan. 21	1 1 2 2 2	Plat	y Iana
Prederick Schultheis Leana Newman State Companies State		yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1	
Frederick Schultheis Leana Newman 19th Malifery Address (Street and Alumber or Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Alumber or Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Alumber or Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Alumber or Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Alumber or Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Alumber or Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumb		a-f e	ctor	Maryland Bal	timore					Dund	alk			1 Yes 2K No
Frederick Schultheis Leana Newman 19th Malifery Address (Street and Alumber or Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Alumber or Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Alumber or Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Alumber or Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Alumber or Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Alumber or Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumb		or 28	Jire	10e. Street and Number				10f. Z	p Code			10g. Citizen	of What Coun	itry?
Prederick Schultheis Leana Newman State Companies State		23a	rai	812 Jeannette A										
Frederick Schultheis Leana Newman 19th Malifery Address (Street and Alumber or Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Alumber or Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Alumber or Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Alumber or Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Alumber or Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Alumber or Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumb	00	s after des		1 Never Married 2 Married	Armed Fo	orces? 2 ☐ No		If Yes, sp	cify Cubar	n, Mexican, Puert	pecify Yes or No- o Rican, etc.)		Black, White,	etc.
Frederick Schultheis Leana Newman 19th Malifery Address (Street and Alumber or Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Alumber or Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Alumber or Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Alumber or Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Alumber or Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Alumber or Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumber City or Town, State, Zp Code) 19th Malifery Address (Street and Pland Rumb	Š	hour turel'				1942		dent's Hs	ial Occupa	tion		16h Kind o		
Prederick Schultheis Leana Newman State Companies State	ה ה	in 72	ojet	(Specify only highest gr	ade completed)		(Give	kind of w	ork done d use retired)	uring most of wor	king	100.74.10		200.17
Prederick Schultheis Leana Newman State Companies State	7	iene.	mo		College (1-40(5+)	Su	perv:	isor			Ye	ast Pla	ant
Physician //Medical Examiner Physician //Medical Physician //Medi	2	Hyg other	a		')					18. Mother's Nar	ne (First, Middle,	Maiden Sur	mame)	
Physician //Medical Examiner Physician //Medical Physician //Medi	O	Aenta Aenta rked tic ev		Frederick Schu	1theis					Lean	a Newmar	ı		
Physician //Medical Examiner Physician //Medical Physician //Medi	ary	should have some					19b. Maili	ng Addres	s (Street a					Code)
Physician //Medical Examiner Physician //Medical Physician //Medi	Ξ,	and 2 saith in 27 in 27 in er tre		Mrs. Doris B. Sc	hulthei					e Ave.				
Physician //Medical Examiner Physician //Medical Physician //Medi		of He of He fitem r oth			□Removal from		Place of Dispo cemetery, crea	natory or	ime of other place	9)	Date	20c. Locati	on - City or To	wn, State
Physician //Medical Examiner Physician //Medical Physician //Medi	Ĕ	Pag nent ent: I ury o		4 ☐ Donation 5 ☐ Other (Speci	fy)	Oa	k Lawn	Ceme	etery	5/26/2	005	Balt	imore,	Maryland
Physician / Medical Examiner Examin	Dall	permit. Departifimport any inj		21. Signature of Funeral Service Lice	nsee		D	uda-1	Ruck :	Funeral				
Physician / Medical Examiner Examin				23a Part1, Enter the dispase, or com shock, or heart fature. List only	plications that of	caused the deat	h. Do not ent	ter the mo	de of dying	such as cardiad	or respiratory ar	rest,		Interval Between
Sequentially list conditions, cause. Enter Underlying Cause. Enter Underlying	y	Physician		Immediate Cause (Final	. 1	Rospiv	aliry							Onset and Death
Due to (or as a consequence of): Considerable				Due to (or as a opnsequence of):										
De to Cor as a consequence of): FEMALE: 23b. Was decedent pregnant in the past 12 months? 23d. If yes, outcome of pregnancy 12l. Live birth 2 Fetal death 3 Ectopic pregnancy 12l. Live b		Examiner		Sequentially list conditions,	b. Ch	rome Ob		my lu	Imm	any Do	Sease			
FEMALE: 23b. Mas decedent pregnant in the past 12 months? 1 1 1 1 1 1 1 1 1		sit sit	iner	if any, leading to immediate cause. Enter Underlying	Due to	(or as a conseq	uence of):			Į.				
FEMALE: 23b. Mas decedent pregnant in the past 12 months? 1 1 1 1 1 1 1 1 1		and -trans	каш	that initiated events	c. Due to	for as a consen	mence of):				-			
FFEMALE: 20 Was decedent pregnant at time of death 2 Felatideath 2 Felatideath 3 Felat	oC,	be ex cian burial	ai E		54010	(0. 23 2 30.1300	201100 017.							
FFEMALE: 20 Was decedent pregnant at time of death 2 Felatideath 2 Felatideath 3 Felat	0	physi the I	dica	•	d									
9 Unknown 1	×	ding			23c. If yes, ou	tcome of pregna	ancy					23d	Date of delive	irv
9 Unknown 9 Unkn	0	atter I for u	ciar	in the past 12 months?										
State Stat		the d y the ached	iysi											
State Stat	, z	ires that signed b	ρ	Part II. Other significant conditions	contributing to d	leath but not res	ulting in the u	nderlying	cause give	n in Part f.				
State Stat		requ been shoul	etec								24a Was	20 20	th Were autor	nev findings available
25. Was case referred to medical examiner? 1	ě	has ge 2	mp								autop	med3/	prior to cor death?	npletion of cause of
27. Manner of Death Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28c. Location (Street and Number or Rural Route Number, City or Town, State) 28c. Place of Injury 28b. Time of Injury 28c. City or Town, State) 28c. Place of Injury 28c. City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury 28c. City or Town, State) 28e. Clauding 28c. City or Town, State 28c. City or Town, State 28c. City or Town, State 28c. City or Town, State 28c. City or Town, State 28c. City or Town, State 28c. City or Town, State 28c. City or Town, State 28c. City or Town, State 28c. City or Town, State 28c. City or Town, State 28c. City or Town, State 28c. City or Town,			O	OS Man area referred to medical						OC Plans of Das			1 ∐ Yes	2∐ No
27. Manner of Death Natural 2 Accident 3 Suicide 4 Homicide See Place of Injury At home, farm, street, factory, office See Place and Injury See Place of Injury At home, farm, street, factory, office See Place and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier See Place of Injury See Place of I	<u> </u>	certi	00	examiner?	Hospital:	Innationt 2	ER/Outpatier	y 3□□	Othe		-		Other (Specific	
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 31. Date filed (Month, Day, Year) 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	5	r this	-		28a. Date	of Injury	28b. Time o							7
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 31. Date filed (Month, Day, Year) 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	0	th. : Afte	tlor	in the state of th		itn, Day Year)	Injury							
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 31. Date filed (Month, Day, Year) 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	S	Atter r dea ector by the	ifica	3 ☐ Suicide 6 ☐ Could not 8	289. Place	of Injury - At h	ome, farm, sti	eet, facto	ry, office		28f. Location (S	Street and No	umber or Rura	l Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jamshid Mian, M.D. 1576 Merritt Blvd. Suite 14 Dundalk, Maryland 21222 State 31. Date filed (Month, Day, Year) 32. Physistra's Signature	5	s afte	Sert	4 Homicide	Build	ing, etc. (Specin	y/				Only or You	n, clate)		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jamshid Mian, M.D. 1576 Merritt Blvd. Suite 14 Dundalk, Maryland 21222 State 31. Date filed (Month, Day, Year) 32. Physistra's Signature		e Hospit 24 hour e Funera etety fille		(Check only 2 Medical Exe	miner: On the b	asis of examina								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jamshid Mian, M.D. 1576 Merritt Blvd. Suite 14 Dundalk, Maryland 21222 State 31. Date filed (Month, Day, Year) 32. Physistra's Signature		ro th vithin ro th ompl	Me	29b. Signature and title of certifier	11	/		29	c. License	number	7	29d. Date si	gned (Month,	Day, Year)
State 31. Date filed (Month, Day, Year) 32. Physistra's Signature		b- > b- ()		I Jan sla	el W	lean	MIS		D5	2889	>	05	1241	05
State 31. Date filed (Month, Day, Year) 32. Physistra's Signature	1	1)		30. Name and address of person who	completed caus	se of death (Iter	n 23a) (Type,	Print)	Jamsh	nid Mian	, M.D.			
State 31. Date filed (Month, Day, Year) 32. Progistrar's Signature	6	Jr 11										22		
				31. Date filed (Month, Day, Year)	32. F		ature	hack	,					

		State of Maryland / Dep 1 - State Registrar AMEND ITEM #14 PER FH G844 &/				ene . No.2 0 0 5	18496
Physicia	n	1. Decedent's Name (First, Middle, Last) Eugene Clifford Spencer, Sr		2	Date of Death Month May 30	Day 2005	3. Time of Death 5:45am M
/Medica Examine		4a. Facility Name (If not institution, give street and number) 1202 Piney Breeze Lane	4b. City, Town, West	or Location of Death		4c. County of Death)
Funeral Director		5. Social Security Number 217-28-5194 Usual Residence of Decedent	y) If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Y Sept 17,	ear) Cou	pplace (State or Foreign intry) MD
Maryland -f show	tor	10a. State 10b. County 10c. City, Town or	Location Airy				10d. Inside City Limits 1 ☐ Yes 2 【XNo
with the a or 28a	Direc	10e. Street and Number 803 E. Ridgeville Boulevard	10f. Zip Code 2177	71	10g	Citizen of What Cou	untry?
ING 21215-0036 be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Exercitive matter actified at	by Funeral Director			Hispanic Origin? (Speci an, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Amer Black, White	
21215-0036 ad within 72 hours aft giene. er than "natural", or it. the Modical Exerti	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occu re kind of work done DO NOT use retire Foreman	during most of working	16	b. Kind of Business/li	
Maryland 2121 d 2 should be filed within th and Mental Hygiene. 77 is marked other than " traumatic event, the Mac	To Be C	17. Father's Name (First, Middle, Last) Willie O. Myers		18. Mother's Name (iden Surname)	
re, Maryla s 1 and 2 should f Health and Men item 27 is marke other traumatic	-			and Number or Rural I		•	
of Heal		1 K Burial 2 Cremation 3 Demoval from State cemetery, cr	E. Kidgev position (Name of ematory or other plant Cemetery	ce) Dat	e 20	ry, MD 21 c. Location - City or T New Windso:	own, State
Baltime permit. Pag Department Important: i any injury o		21. Signature of Funeral Service Licensee	22. Name and Addre		& CHAPEL	. PA (Box	
be executed /Medical Examiner purial-transit	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dyi	ng, such as cardiac or r	espiratory arrest		Approximate Interval Between Onset and Death
Hecords, P.O. Box 68/60, The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medical		□Ectopic pregnanc □ Other (specify) _	у		23d. Date of delive Month	very Day Year
uires that the signed by lid be detac	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause gr	ven in Part I.		cco use contribute to	the cause of death?
	Completed				24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
SION Of VITS tending Physician leath. tor: After this certific the tuneral director.	Certification; To Be	25. Was case referred to medical examiner? 1	of 28c. Inju	Yes 2□No	5 Residence.	injury occurred	Tiving
ospi hou uner ly fill		4 Homicide building, etc. (Specify) 29a. Certifier (Check only Medical Examiner: On the basis of examination and/or			d due to the caus	se(s) and manner as	
To the Hospita within 24 hours To the Funeral completely filled	Medical	29b. Signature and title of Certifier M.D.	29c. Licen:			Date signed (Month, 5/31/05	Day, Year)
lo		30. Name and address of person who completed cause of death (Item 23a) (Type Dr. Gourishankar Naganna 700A Poole R		inster, MD	21157		
State Registra	3.71	31. Date filed (Month, Day, Year) JUN 0 2 2005 32. Registrar's Signature	_				

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2005 Month **Physician** 7:30P M MILDRED JEAN **S00S** 31 Mav /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 8718 Blairwood Road Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 27, 1921 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2XXF 118-24-8580 84 Virginia Director Usual Residence of Decedent the Maryland 10a. State 10b County 10c. City, Town or Location 10d Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8718 Blairwood Road 21236 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 277 No If Yes, Give 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White 3XXWidowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Hospital Dietary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James William Elick Mildred Elizabeth Bridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy A Denning DTR 5332 Castlestone Drive Baltimore, Maryland 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete XX Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 6/4/05 □Donation 5 □ Other (Specify) Baltimore, Maryland ignature of Funeral Service 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one pause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Cancel 6 Months Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed **burial-transit** and Due to (or as a consequence of): P.O. Box 68760, attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy for Year Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 2 1 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 2 No 3□ DOA Certification: To 2 ER/Outpatient After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. adical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number H0050642 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9194 Pristerstown Rd, Suite 1003, Dwars mills, mo 21117 Suncil 0,0 Samuel 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 0 2 2005 Goods Registrar

DHMH 17 Rev 1/2001

SCHOOLER

icia		Registrar 1. Decedent's Name (First, Middle,					2. Date of Death	L	Year	3. Time of Dela 11:30 A
dica	al -		agliola		4. Ch. T.			4c. County	of Dooth	11:30 E
nine	1	4a. Facility Name (If not institution, 208 J CLARKSPII	CE CT		BELA	or Location of Death IR			FORD	CO
al or		Clarkes R 5. Social Security Number 128-40-4496	. Sex 7. Age	(In yrs. last birth	Months Davs	Hours Min.	8. Date of Birth (Month, Day, JAN • 13	, 1949	9. Birthr Cour Ne	place (State or For htry) W York
	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				1	Od. Inside City Li
	ō	MD Harfor	oo b	BELAIR						1 ☐ Yes 2 🔀
	Director	10e. Street and Number 208 ClarksRidge			10f. Zip Code 21015		10	g. Citizen of V USA	Vhat Cou	ntry?
	Funeral	11. Marital Status	12. Was Decedent B	ever in U.S.	13. Was Decedent of If Yes, specify Cub		pecify Yes or No-	14. Race		can Indian,
	by Fun	1 Never Married 2 Marrie 3 Widowed 4 ☑ Divorced	Armed Forces? d 1 X Yes 2 □ N If Yes, Give Year or Dates:	lo	If Yes, specify Cub 1 ☐ Yes 2X No		Rican, etc.)	Specify	k, White, Wh	etc. ite
	Completed	15. Decedent's (Specify only highest	grade completed)		Decedent's Usual Occu Give kind of work done life. DO NOT use retire	pation during most of worked)	king	6b. Kind of Bu	usiness/In	dustry
	шо	Elementary/Secondary (0-12)	College (1-4or 5	+)	Physicia	n		Health	ı Car	e
	Be C	17. Father's Name (First, Middle, La					ne (First, Middle, N	laiden Sumam	16)	
	2	Henry J. Scag					'ontana	O: T	O	0-1-1
7		19a. Informant's Name/Relationshi		9554	Mailing Address (Stree					Code)
1		Angela Scagliola 20a. Method of Disposition	a – daugnter		Duncannor Disposition (Name of crematory or other pla			D• 210 loc. Location -		own, State
		1X Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		_ m	Cemetery	6/4/2	.005 W	oodside	e, Ne	w York
once.		21. Signature of Funeral Service Li	censee		Gary L. Ka	ess of Facility ufman Fun	eral Hom	e @ Mead	dowri	dge MP, I
		23a. Part1. Enter the lisease, or o shock, or heart failure. List o	omplications that caused	the death. Do no						Approximate Interval Between
n		Immediate Cause (Final disease or condition	-		cardiovas	cular dis	ease			Onset and Dea
al. er		resulting in death)		a consequence of						
: []	-	Sequentially list conditions, if any, leading to immediate cause Frite Linearitying	b. Due to (or as	a consequence of	i):					
	Examiner	Cause (Disease or injury that initiated events	c							
	cal Ex	resulting in death) Last	Due to (or as	a consequence of	·):					
	()		d							
								23d. Dat	te of deliv	ery Day Yea
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	су		Мо		
		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death time of death	5 ☐ Other (specify)		23e. Did tob			he cause of deat
	by Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death time of death	5 ☐ Other (specify)			acco use cont	ribute to t	
	by Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death time of death	5 ☐ Other (specify)		1 □ Ye	acco use cont	ribute to t	bably 4 Unk
	by Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death time of death	5 ☐ Other (specify)		1 ☐ Ye 24a. Was ar autops	acco use conto	ribute to t	bably 4 Unk
		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death time of death	5 ☐ Other (specify) _	ven in Part I. 26. Place of Dea	1 Ye 24a. Was are autops perform 1/2 Yes 2	acco use cont s 2 No 1 24b. V Hed?	Professional Profession to codeath?	opsy findings avaimpletion of caus
	To Be Completed by Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 ▼ Yes 2 □ No	1 Live birth 4 Pregnant at 9 Unknown Is contributing to death be Hospital: 1 Inpatie	2 Fetal death time of death ut not resulting in	5 ☐ Other (specify) ☐ the underlying cause g	ven in Part I. 26. Place of Deather: 4 ☐ Nursing H	1 Yes 24a. Was an autops perform	acco use cont s 2 No n 24b.	ribute to t 3 Prol Were autorior to codeath? Yes	opsy findings avaimpletion of caus
	To Be Completed by Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1	1 Live birth 4 Pregnant at 9 Unknown Is contributing to death be Hospital: 1 Inpatie 28a. Date of Inju (Month, Da)	2 Fetal death time of death ut not resulting in	5 ☐ Other (specify) ☐ the underlying cause g patient 3 ☐ DOA me of 28c. Injury	ven in Part I. 26. Place of Deather: 4 ☐ Nursing H	1 Ye 24a. Was are autops perform 14 Yes 2 th (Check only one one 5 The Reside	acco use cont s 2 No n 24b.	ribute to t 3 Prol Were autorior to codeath? Yes	popsy findings avampletion of caus
	To Be Completed by Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1	Hospital: 28a. Date of Inju (Month, Da)	2 Fetal death time of death time of death time of death ut not resulting in the control of the c	5 ☐ Other (specify) ☐ the underlying cause g patient 3 ☐ DOA me of 28c. Injury	26. Place of Deather: 4 □ Nursing H	1 Ye 24a. Was are autops perform 14 Yes 2 th (Check only one one 5 The Reside	acco use cont s 2 No led? led? loce 6 VOth w injury occurr	ribute to to a 3 proliferation of the control of th	(y) SCENE
	Certification: To Be Completed by Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1	Hospital: 28a. Date of Injunction 1 Liphysician: To the basts of the	2 Fetal death time of death time of death ut not resulting in the control of the	obtailent 3 DOA Come of Larry Mr. street, factory, office death occurred at the	26. Place of Deather: 4 □ Nursing Hury at ork? Yes 2 □ No	24a. Was are autops perform 1/2 Yes 2 th (Check only one ome 5 Reside 28d. Describe how the case of the control of the case	acco use cont s 2 No led? led? lod? lod? lod? lod? lod? lod? lod? lo	Were autoprior to codeath? If (Special Performance of the Company	opsy findings avaimpletion of caus 2 No NO SCENE
	To Be Completed by Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1	Hospital: 28a. Date of Inju (Month, Da) atton by 28e. Place of Inju building, etc.	2 Fetal death time of death time of death ut not resulting in the control of the	oatient 3 DOA Containing and DOA Mee of Jury Mingury M	26. Place of Deather: 4 \(\) Nursing H 10 y at 10 y 2 \(\) No 11 yes 2 \(\) No 12 ime, date and place 13 opinion, death occur 15 ise number	24a. Was an autops perform 1/2 Yes 2 th (Check only onloome 5 - Reside 28d. Describe ho 28f. Location (St. City or Town on automatical the time, date at the time, date and the time, date at the time, date and the time, da	acco use cont s 2 No led? led? lod? lod? lod? lod? lod? lod? lod? lo	Were autorior to codeath? Were find Yes Were find Yes Were find Yes Were autorior to codeath? Were autorior to codeath. Wer	post findings available of caus 2 No No SCENE al Route Number stated. o the cause(s)
	edical Certification: To Be Completed by Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1	Hospital: 28a. Date of Injunction 1 Liphysician: To the basts of the	2 Fetal death time of death time of death ut not resulting in the control of the	oatient 3 DOA Continuous and DOA Mee of Jury Minus 1 Comments and	26. Place of Deather: 4 \(\) Nursing H 10 y at 10 y 2 \(\) No 11 yes 2 \(\) No 12 ime, date and place 13 opinion, death occur 15 ise number	24a. Was are autops perform 10 Yes 2 th (Check only one ome 5 Reside 28d. Describe how 28d. Describe how 28d. Location (St. City or Town), and due to the carred at the time, day	acco use control of the control of t	Were autorior to codeath? The	opsy findings avaimpletion of caus 2 No No SCENE al Route Number stated. to the cause(s) Day, Year)

			State of Maryland / Dep	partment of Health and I		ene g. No. 2005	18500
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia		Susie R. Sullivan		May 29,	2005	10:30 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Dea	
			8 Fort Hoyle Road	Joppa		Harfo	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	/) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign puntry)
	Director		217-56-5979 1 M 2 F 85 Yrs.		Feb. 26,		irginia
	DG .	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	ocation			10d. Inside City Limits
	aryla shov	-	10a. State 10b. County 10c. City, Town or	Location			1 ☐ Yes 2 🔂 No
	8a-f	cto	Maryland Harford Jopp		10	ng. Citizen of What Co	
	or 2	Director	10e. Street and Number	10f. Zip Code	10		ountry :
	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, il w Mc-dical Examinational be notified at	ra a	8 Fort Hoyle Road	21085	pacifu Vas or No-	USA 14. Race - Ame	encan Indian
	er de Itema	Funeral		. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, Whi	
36	s aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify:	White
21215-0036	hour tural	ed t	15 Decedent's Education 16a Dec	edent's Usual Occupation	1	16b. Kind of Business	
5	in 72 "na "ulic	Completed	(Specify only highest grade completed) (Gi	re kind of work done during most of wor DO NOT use retired)	rking		
12	within iene. than	E O	Elementary/Secondary (0-12) College (1-4or 5+)	memaker		Own Home	9
	I Hygie other t		17. Father's Name (First, Middle, Last)		ne (First, Middle, M	faiden Sumame)	
an		o Be	Percy Lee Burton	Mary	Frances	Simpson	
Maryland	E B B G		19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ling Address (Street and Number or Ru	ıral Route Number,	City or Town, State,	Zip Code)
Ĕ	nd 2:		Valerie J. Blevins / Daughter	16 Fort Hoyle Road	d, Joppa,	MD 21085	
<u>o</u>	s 1 a		cometery c	oosition (Name of ematory or other place)	Date 2	20c. Location - City or	Town, State
9				w Memorial Grdns (5-2-05	Fallston,	Maryland
Baltimore,				22. Name and Address of Facility MCCOMAS FUNETAL HO	ma D 7		_
ã	permit. Departr Importa any inju		Made T- 200	1317 Cokesbury Roa	ad. Abing	don, MD 21	1009
	- 1		23a. Part1. Enter the disease, or complications that caused the death. Do not a				Approximate Interval Between
Ш			shock, or heart failure. List only one cause on each line. Immediate Cause (Final	ERIS DISE	ASE		Onset and Death
	Pnysician /Medical		disease or condition resulting in death) Due to (or as a consequence of):				
	Examiner		ATHEROSCUE	ROTIC CARDIO	VISCUL	AR DISERS	E OVER 4 CM
١,		ē	Sequentially list conditions, if any loading to immediate Due to (or as a consequence of):				
V	uted d ansit	Examine	Cause (Disease or injury that initiated events	LTI INFARET	5		ENER 4 4.5 M
Ć.	be executed sician and burial-transit		resulting in death) Last	· La · Land A T	TALLIN	01	OVER 14EM
8760	9 % 9	cal	CON RUST	IVE HEART	TILUM	00	7.57
9	leath certifical attending phi I for use as th		10 FEW 10				
Вох	h cer endir	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	□Ectopic pregnancy		23d. Date of de	
	deat	ick		Other (specify)		Month	Day Year
P.0	t the de by the a	hys	9 Li Unknown				
	es tha igned be det	by F	Part II. Other significant conditions contributing to death but not resulting in the OSTED ARTHROUNDS AF SI	underlying cause given in Part I.		acco use contribute t	
ğ	w require been si		USIEU AFINICIVIS OF SI	1100	1 🗆 Ye	s 2 No 3 P	robabiy 4 Dunknown
Records,	aw re as be 2 sh	Completed			24a. Was ar autopsy	y prior to	utopsy findings available completion of cause of
	The la	E O			perform 1 ☐ Yes 2	ned? death? □ 1 ☐ Yes	s 2 No
Vital	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?	26. Place of Dea	ath (Check only one	9)	
>	S S	ToE	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	ent 3 DOA Other: 4 Nursing F	lome 5 Reside	nce 6 Other (Spe	ecify)
ا و ر	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time (Month, Day Year) Injur		28d. Describe ho	w injury occurred	
Ö	Attending r death.	atle	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division	er de recto	Certification;	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide	street, factory, office	28f. Location (Str City or Town	eet and Number or R , State)	ural Route Number,
	rs afte al Dire	Cer			ſ		
	Hospital 4 hours a Funeral tely filled	edical	29a. Certifier 12 Certifying Physicien: To the best of my knowledge, de (Check only) 2 Medicel Examiner: On the basis of examination and/or	ath occurred at the time, date and place investigation, in my opinion, death occu	e, and due to the ca urred at the time, da	iuse(s) and manner a ite and place, and du	s stated. e to the cause(s)
	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	led	one) and manner stated.	29c. License number		d. Date signed (Mon	
	To To Con	Σ	29b. Signature and title of certifier	DOD16 35			
			Januar M.D.				
	6		30. Name and address of person who completed cause of death (Item 23a) (Typ. PERFEC'TO C, VALARAO, M, D. 171	6 HARFORD ROAD	SultE10	6 FALLST	ON 140 21047
	Sta Regist		31. Date filed (Month, Day, Year) JUN 0 2 2005	E)			
	-						